MEDICARE PREVENTIVE BENEFITS ACT OF 1991

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

H.R. 2565

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE FOR COVERAGE OF COLORECTAL SCREENING EXAMINATIONS AND CERTAIN IMMUNIZATIONS UNDER PART B OF THE MEDICARE PROGRAM, AND FOR OTHER PURPOSES

JUNE 20, 1991

Serial 102-43

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MEDICARE PREVENTIVE BENEFITS ACT OF 1991

THURSDAY, JUNE 20, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 1 p.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing, and a copy of the bill, H.R. 2565, follow:]

FOR IMMEDIATE RELEASE
THURSDAY, JUNE 13, 1991

PRESS RELEASE #14
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON H.R. 2565, THE "MEDICARE PREVENTIVE BENEFITS ACT OF 1991"

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Medicare preventive benefits, including, H.R. 2565, the "Medicare Preventive Benefits Act of 1991." The hearing will be held on Thursday, June 20, 1991, beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

On June 6, 1991, H.R. 2565, the "Medicare Preventive Benefits Act of 1991" was introduced by Committee Chairman Dan Rostenkowski (D., Ill.), for himself, Mr. Stark, (D., Calif.), Mr. Chandler (R., Wash.), and 21 other Members of the Committee. A companion bill, S. 1231, was introduced in the Senate on June 6 by the Honorable Lloyd Bentsen (D., Texas), Chairman of the Senate Finance Committee. These bills would provide Medicare coverage for certain preventive services outlined below.

In announcing the hearing, Chairman Stark stated, "While Medicare pays for the treatment of illness, it does very little to encourage the prevention or early detection of illness. Prevention not only saves money, but also reduces unnecessary pain and suffering."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

SCOPE OF THE HEARING

H.R. 2565, would provide Medicare coverage for colorectal cancer screening, influenza and tetanus vaccinations, annual mammography screening for older women, and coverage of well-child care for Medicare end-stage renal disease beneficiaries under the age of seven. The bill would also authorize a series of demonstration projects to determine the appropriateness of providing coverage of other preventive services. Also, the Office of Technology Assessment would conduct a study and recommend a process for determining when other preventive services should be covered under Medicare.

In addition, the Subcommittee invites testimony on a proposed increase of $1.10 per month in 1992, increasing to $1.60 per month in 1996, in the Part B premium to finance H.R. 2565. Such a financing mechanism, or an alternative, is required under the pay-as-you-go provisions enacted in last year's budget reconciliation bill.

(MORE)

BACKGROUND

Preventive services generally have not been reimbursed under Medicare. With limited exceptions, Medicare payment for preventive services is specifically prohibited under Section 1862 of the Social Security Act. Services covered by Medicare under current law, and the effective dates of the benefits, are:

* Pneumococcal vaccine, since 1980;

* Hepatitis B vaccine for certain high-risk individuals, since 1984;

* Pap smears to screen for cervical cancer, since July, 1990; and

* Biennial mammography screening for breast cancer, since January 1991.

In 1991, an estimated 155,000 new cases of colon/rectal cancer will be identified, and 61,000 people will die of this disease. Patient survival depends on the extent of the disease at the time of diagnosis. Screening, through periodic fecal occult blood tests and sigmoidoscopies, can mean earlier detection and a less life-threatening diesease. The Department of Health and Human Services' health promotion and disease prevention goals for the year 2000 include substantial increases in the number of people who are routinely screened for colorectal cancer.

In 1991, an estimated 150,000 new cases of breast cancer will be diagnosed, and 44,000 women will die of this disease. Studies have confirmed the effectiveness of mammography screening in reducing breast cancer mortality.

The Medicare benefit for mammography screening enacted in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) includes certain limits on the frequency with which mammography screening would be covered. For women ages 65 and above, mammography screening is covered only once every two years. The American Cancer Society recommends annual screenings for women over age 50.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, July 1, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

102D CONGRESS
1ST SESSION

H. R. 2565

To amend title XVIII of the Social Security Act to provide for coverage of colorectal screening examinations and certain immunizations under part B of the medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 6, 1991

Mr. ROSTENKOWSKI (for himself, Mr. STARK, Mr. CHANDLER, Mr. GIBBONS, Mr. PICKLE, Mr. RANGEL, Mr. JACOBS, Mr. JENKINS, Mr. GUARINI, Mr. MATSUI, Mr. ANTHONY, Mr. DORGAN of North Dakota, Mrs. KENNELLY, Mr. COYNE, Mr. ANDREWS of Texas, Mr. LEVIN of Michigan, Mr. MOODY, Mr. CARDIN, Mr. MCDERMOTT, Mr. VANDER JAGT, Mr. SCHULZE, Mr. THOMAS of California, Mr. MCGRATH, and Mrs. JOHNSON of Connecticut) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend title XVIII of Social Security Act to provide for coverage of colorectal screening examinations and certain immunizations under part B of the medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Preventive Benefits Act of 1991".

SEC. 2. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4163(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as "OBRA–1990"), is amended by inserting after subsection (c) the following new subsection:

"(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS AND SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

"(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to screening fecal-occult blood tests provided for the purpose of early detection of colon cancer, except as provided by the Secretary under paragraph (3)(A), the payment amount established for tests performed—

"(i) in 1992 shall not exceed $5; and

"(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer—

"(i) if the individual is under 50 years of age; or

"(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

"(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for

a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer—

"(i) if the individual is under 50 years of age; or

"(ii) if the procedure is performed within the 59 months after a previous screening flexible sigmoidoscopy.

"(3) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

"(A) REDUCTIONS IN PAYMENT LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 1994, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National

Cancer Institute, shall review periodically the appropriate frequency for performing screening fecal-occult blood tests and screening flexible sigmoidoscopies based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such revision shall apply to tests or procedures performed before January 1, 1995.

"(4) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as

defined in subparagraph (B), or, if less, as defined in section 1848(g)(2)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to a procedure performed—

"(i) in 1992, 120 percent of the payment limit established under paragraph (2)(A); or

"(ii) after 1992, 115 percent of such applicable limit.

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(b) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) of such Act (42 U.S.C. 1395l(a)) are each amended by striking "subsection (h)(1)," and inserting "subsection (h)(1) or section 1834(d)(1),".

(2) Section 1833(h)(1)(A) of such Act (42 U.S.C. 1395l(h)(1)(A)) is amended by striking "The Secretary" and inserting "Subject to paragraphs (1) and (3)(A) of section 1834(d), the Secretary".

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) of such Act (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by striking "a service" and inserting "a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer)".

(4) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking "and" at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting ", and", and

(iii) by adding at the end the following new subparagraph:

"(G) in the case of screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);"; and

(B) in paragraph (7), by striking "paragraph (1)(B) or under paragraph (1)(F)" and inserting "subparagraphs (B), (F), or (G) of paragraph (1)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to screening fecal-occult blood tests and screening flexible sigmoidoscopies performed on or after January 1, 1992.

SEC. 3. COVERAGE OF CERTAIN IMMUNIZATIONS.

(a) IN GENERAL.—Section 1861(s)(10) of the Social Security Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) in subparagraph (A)—

(A) by striking ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,", and

(B) by striking "; and" and inserting a comma;

(2) in subparagraph (B), by striking the semicolon at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(C) tetanus-diptheria booster and its administration;".

(b) LIMITATION ON FREQUENCY.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by section 2(b)(4)(A), is amended—

(1) in subparagraph (F), by striking "and" at the end;

(2) in subparagraph (G), by striking the semicolon at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(H) in the case of an influenza vaccine, which is administered within the 11 months after a previous influenza vaccine, and, in the case of a tetanus-diptheria booster, which is administered within the 119 months after a previous tetanus-diptheria booster;".

(c) CONFORMING AMENDMENT.—Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 2(b)(4)(B), is amended by striking "or (G)" and inserting "(G), or (H)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to influenza vaccines and tetanus-diptheria boosters administered on or after January 1, 1992.

SEC. 4. COVERAGE OF WELL-CHILD CARE.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 4201(d)(1) of OBRA–1990, is amended—

(1) by striking "and" at the end of subparagraph (O);

(2) by striking the semicolon at the end of subparagraph (P) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(Q) well-child services (as defined in subsection (ll)(1)) provided to an individual entitled to benefits under this title who is under 7 years of age;".

(b) SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) added by section 4163(a)(2) of OBRA–1990 as subsection (kk); and

(2) by inserting after subsection (kk) (as so redesignated) the following new subsection:

"WELL-CHILD SERVICES

"(ll)(1) The term 'well-child services' means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care, provided in accordance with the periodicity schedule established with respect to the services under paragraph (2).

"(2) The Secretary, in consultation with the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with

which the services referred to in paragraph (1) should be provided to healthy children.".

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by sections 2(b)(4)(A) and 3(b), is amended—

(A) in subparagraph (G), by striking "and" at the end;

(B) in subparagraph (H), by striking the semicolon at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(I) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(ll)(2) for such services;".

(2) Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by sections 2(b)(4)(B) and 3(c), is amended by striking "or (H)" and inserting "(H), or (I)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to well-child services provided on or after January 1, 1992.

SEC. 5. ANNUAL SCREENING MAMMOGRAPHY.

(a) ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the So-

cial Security Act (42 U.S.C. 1395m(b)(2)(A)), as added by section 4163(b)(2) of OBRA-1990, is amended—

(1) in clause (iv), by striking "but under 65 years of age,"; and

(2) by striking clause (v).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to screening mammography performed on or after January 1, 1992.

SEC. 6. DEMONSTRATION PROJECTS FOR COVERAGE OF OTHER PREVENTIVE SERVICES.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (hereafter referred to as the "Secretary") shall establish and provide for the conduct of a series of ongoing demonstration projects under which the Secretary shall provide for coverage of the preventive services described in subsection (c) under the medicare program in order to determine—

(1) the feasibility and desirability of expanding coverage of medical and other health services under the medicare program to include coverage of such services for all individuals enrolled under part B of title XVIII of the Social Security Act; and

(2) appropriate methods for the delivery of those services to medicare beneficiaries.

(b) SITES FOR PROJECT.—The Secretary shall provide for the conduct of the demonstration projects established under subsection (a) at the sites at which the Secretary conducts the demonstration program established under section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and at such other sites as the Secretary considers appropriate.

(c) SERVICES COVERED UNDER PROJECTS.—The Secretary shall cover the following services under the series of demonstration projects established under subsection (a):

(1) Glaucoma screening.

(2) Cholesterol screening and cholesterol-reducing drug therapies.

(3) Screening and treatment for osteoporosis, including tests for bone-marrow density and hormone replacement therapy.

(4) Screening services for pregnant women, including ultra-sound and clamydial testing and maternal serum alfa-protein.

(5) One-time comprehensive assessment for individuals beginning at age 65 or 75.

(6) Other services considered appropriate by the Secretary.

(d) REPORTS TO CONGRESS.—Not later than October 1, 1993, and every 2 years thereafter, the Secretary shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives describing findings made under the demonstration projects conducted pursuant to subsection (a) during the preceding 2-year period and the Secretary's plans for the demonstration projects during the succeeding 2-year period.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Supplementary Medical Insurance Trust Fund for expenses incurred in carrying out the series of demonstration projects established under subsection (a) the following amounts:

(1) $4,000,000 for fiscal year 1992.

(2) $4,000,000 for fiscal year 1993.

(3) $5,000,000 for fiscal year 1994.

(4) $5,000,000 for fiscal year 1995.

(5) $6,000,000 for fiscal year 1996.

SEC. 7. OTA STUDY OF PROCESS FOR REVIEW OF MEDICARE COVERAGE OF PREVENTIVE SERVICES.

(a) STUDY.—The Director of the Office of Technology Assessment (hereafter referred to as the "Director")

shall, subject to the approval of the Technology Assessment Board, conduct a study to develop a process for the regular review for the consideration of coverage of preventive services under the medicare program, and shall include in such study a consideration of different types of evaluations, the use of demonstration projects to obtain data and experience, and the types of measures, outcomes, and criteria that should be used in making coverage decisions.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Director shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on the study conducted under subsection (a).

Chairman STARK. Good afternoon.

The Subcommittee on Health of the Committee on Ways and Means will begin a hearing examining issues relating to the coverage of preventive services under Medicare. Today we will examine H.R. 2565, the Medicare Preventive Benefits Act of 1991.

Since the beginning of Medicare in 1965, the statutes have expressly prohibited payments for preventive services. Section 1862 of the Social Security Act states that no payments can be made for services that are not, "necessary for the diagnosis and treatment of illness or injury." As a result, Medicare is basically an acute care program, paying for the care of the sick, but doing little to help the elderly retain their health.

Over the past 10 years, this committee has extended Medicare benefits to include a limited number of preventive services. Pneumococcal and hepatitis B vaccines were first covered by Medicare in the early 1980s. More recently, coverage was extended to include Pap smears to detect cervical cancer and mammograms to detect breast cancer. It is time that Medicare sheds its philosophy of only caring for the sick and diseased, and begins to provide routine coverage for effective preventive services.

H.R. 2565 represents a significant step in this direction. The act would provide coverage for services that are widely acknowledged to be effective, and would establish the basis for providing coverage of additional prevention services in the future.

Enactment of H.R. 2565 requires financing under the current pay-as-you-go rules. There are a variety of possible funding sources, including a modest increase in the monthly part B premium. The Chair and the committee will be very interested in the suggestions of our witnesses as to how these benefits could be financed.

I would like to thank all of the witnesses for their time and effort in joining us here today. I know that this hearing is an important step toward enactment of the important preventive benefits provided by H.R. 2565.

This afternoon our first scheduled witness is my colleague Barbara Boxer of California. However, Dr. Roper has a prior commitment and Mrs. Boxer has graciously agreed to accommodate his schedule and defer her statement.

Dr. Roper is an old friend of the subcommittee. We are glad to see you back here again, Bill. We are pleased you are the Nation's top preventive health official as the Director of CDC.

Before you would begin, I would like to note that we have statements for the record from Chairman Rostenkowski and Mr. Regula. Without objection their statements will be part of the record.

[The statements of Chairman Rostenkowski and Mr. Regula follow:]

STATEMENT OF
THE HONORABLE DAN ROSTENKOWSKI, CHAIRMAN
COMMITTEE ON WAYS AND MEANS
ON
THE MEDICARE PREVENTIVE BENEFITS ACT OF 1991
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS

June 20, 1991

Mr. Chairman, I am pleased to appear before you today in support of H.R. 2565, the Medicare Preventive Benefits Act of 1991, a bill that I introduced along with you and 22 of our colleagues on the Committee on Ways and Means. An identical bill, S. 1231, was introduced in the Senate by Senator Bentsen, whose support and cooperation on this legislation I greatly appreciate. I also appreciate, Mr. Chairman, your prompt scheduling of this hearing and look forward to the testimony on the bill.

The merits of prevention are obvious to everyone. Yet, surprisingly, it is only in the last ten years that Congress has permitted Medicare to pay for any preventive services. In 1980, we began paying for pneumococcal vaccines. In 1984, hepatitis B vaccines for certain high-risk individuals were authorized. Last year, we added pap smears to test for cervical cancer and mammography screening for breast cancer.

Today's hearing is on H.R. 2565, a bill that proposes the next step along the continuum of possible preventive services. It would expand prevention in three areas.

First, H.R. 2565 would permit Medicare reimbursement for colorectal cancer screening and replace the current policy of biennial mammograms for elderly women with authority for annual screenings, as recommended by the American Cancer Society.

Second, the bill would cover annual influenza vaccinations for the elderly and tetanus vaccinations every ten years.

Third, H.R. 2565 would cover well-baby and well-child care, including appropriate immunizations for the small number of children who are eligible for Medicare through the end-stage renal disease program. These services are appropriate for all small children and should be available to Medicare beneficiaries.

The bill would also authorize permanent demonstration projects relating to preventive services and would require the Office of Technology Assessment to recommend a process for determining when other preventive services should be covered under Medicare.

The first question I would ask about this bill were I chairing the hearing today is, how much does it cost and how will we pay for it. When I introduced H.R. 2565 I didn't suggest a specific financing mechanism because I wanted to focus the public debate on the health policy aspects of the basic proposal.

However, as all Members of the Subcommittee know, I am fully committed to the pay-as-you-go requirements that were enacted in last year's deficit reduction bill. In fulfillment of those requirements, I have suggested that one way to pay for the bill would be a modest increase in the Medicare Part B premium. I am told that, based on preliminary estimates, these benefits could be fully financed by an increase in the premium of $1.10 per month in 1992. This would rise annually and, by 1996, would result in an extra $1.60 per month. I will be interested to hear what your other witnesses today have to say about the merits of this legislation, and equally important, what financing mechanism they would support.

Mr. Chairman, preventive services can save lives and save money. They can prevent disease, assure early detection and often offer the best chance we have to reduce mortality and duration of illness. I sincerely believe that H.R. 2565 is the next logical step in our efforts to assure sensible and affordable health coverage for American citizens. I hope that the Subcommittee agrees, and that it will give H.R. 2565 its prompt and enthusiastic support.

Statement of Hon. Ralph Regula, a Representative in Congress from the State of Ohio

Mr. Chairman:

Over a decade ago, the Surgeon General's report on Health Promotion & Disease Prevention stated, "Improvement in the health status of our citizens will not be made predominantly through the treatment of disease, but rather through its prevention." This call for change in federal policy has been repeated in numerous studies over the years but has gone largely ignored.

Late last year, the Select Committee on Aging conducted a hearing reviewing the need for expanding Medicare to include an assortment of preventive health services. At that time over one hundred members joined in supporting such an expansion, which is now embodied in HR1746. Today's hearings will continue that effort and hopefully result in fulfillment of our common goal.

Clearly, the successes of such tests have been repeatedly demonstrated. For example, the control of high blood pressure is seen as one of the most effective ways for reducing death rates from heart disease and stroke. Since 1978 the death rate from heart disease has fallen 10%, the death rate from stroke has fallen 25%.

One out of four Americans have high blood cholesterol. Increased blood cholesterol levels, more specifically increased levels of LDL-cholesterol, are causally related to an increased risk of coronary heart disease (CHD). Coronary risk rises progressively with cholesterol level, particularly when cholesterol levels rise above 200 mg/dl. There is also substantial evidence that lowering total and LDL-cholesterol levels will reduce the incidence of CHD.

In a recent national study, nearly 13,000 men and women were screened at 11 lipid research centers across the country. Roughly 25% had blood cholesterol levels though to place them at moderate risk of heart disease, defined as 200 milligrams per deciliter at age 20, 220 at age 30, and 240 at age 40 and above.

Scientists from the National Heart. Lung, and Blood Institute have reported testing for hypertension can effectively be conducted in shopping centers, workplaces and schools. It also found that nearly half of the people identified as being at high risk of heart disease will contact their physicians for follow-up care.

Another example, is a program I was successful in enacting into law which requires Medicare to provide influenza shots to Medicare recipients. I am pleased to note the committee's bill builds upon this program to expedite its permanent inclusion into the program.

Despite similar studies revealing how certain preventive health tests can significantly improve the quality and length of life in such diseases as colon, cervical, and breast cancer the government continues to refuse to reimburse for these treatments. Medicare payments are largely limited to the payment of pneumonia and hepatitis vaccinations, and more recently flu shots.

Common sense dictates that this policy be changed. Both lives and money will be saved.

In the past two Congresses, I have introduced legislation to require Medicare to consider coverage of preventive health services to the elderly. In April, over one hundred Members of Congress joined together to support bipartisan legislation, HR1746, which closely resembles the bill now before the Committee. I would hope these members would now join me in supporting your legislation Mr. Chairman.

However, I would raise two concerns with the legislation as it is currently drafted. I refer to the provisions regarding reimbursement of colorectal examinations and influenza vaccination. These are both areas of which I have longstanding familiarity.

First, the Committee's decision to include colon screening examinations as a reimbursable Medicare benefit is commendable and necessary. Fecal stool blood tests are a recognized and very reliable means for determining irregularities within both the upper and lower colon. But, as the committee knows, the test does not conclusively establish the presence of cancer only that blood is in the stool.

Arguably, inclusion of the flexible sigmoidoscopic screening can confirm the earlier test. Yet, this test is very expensive and uncomfortable for the patient. Furthermore, its ability to locate suspicious pulps in the lower colon is sustained but it remains unconfirmed whether its as successful in locating those in the upper areas of the colon.

For these reasons, fecal blood stool tests should be reimbursed under Medicare, but I would recommend to the Committee that consideration be given to making reimbursement for the flexible sigmoidoscopy conditional upon first a positive test result under the stool examination. Another option would be to test the effectiveness of the sigmoidoscopic screening before permanent inclusion in the program. Either of these alternatives will avoid unnecessary expense and discomfort to poorly informed patients. Tax dollars will be saved without compromising the quality of care.

Second, I would strongly add my support for the permanent inclusion of influenza vaccinations under Medicare.

In 1988, HCFA began implementing legislation which I had introduced requiring a nationwide demonstration project to test the effectiveness of flu shots. Last year over 20,000 lives were saved by the program with an estimated cost savings of $63 million. As the Committee knows, under the enacted statute, the Secretary of Health and Human Services has the authority to make the benefits a permanent part of the program without further congressional consideration. Our continued efforts with the department indicate the program is expected to become permanent within the next year if this current legislation would not become law.

I would suggest the Committee make use of the three years of information we have been able to obtain through the demonstration. The key to making flu shots effective is the point of delivery and targeting high-risk population subgroups. HCFA's accumulated data on this matter can provide a framework for determining the settings under which the benefit would be best reimbursed. An across-the-board reimbursement that does not establish such a framework will be a waste of precious tax-dollars.

In summary, it makes no sense to spend money on care after the onset of an illness when prevention cuts costs and provides a better quality of life for all of us. Once this is achieved, Medicare will be thrust into the modern age where prevention of serious illnesses is the key, not just treating them after they occur.

Medical science has brought to us the ability to preserve life far beyond that of our ancestors. But it is not enough to add year to life. Our objective must also be to add a new vibrance to those years through the use of preventive health care which not only maintains life but maintains it at a higher quality.

Thank you.

Chairman STARK. Bill, before you proceed, I would like to recognize Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

Thank you for holding this important hearing today on H.R. 2565, introduced by Chairman Rostenkowski. H.R. 2565 would provide coverage of preventive services for Medicare beneficiaries which I believe is vitally important. Prevention is the key word in combating potential life threatening illnesses. I am an original sponsor of this important piece of legislation.

I am also a cosponsor of the Older Americans Breast Cancer Prevention Act of 1991, which was alluded to being sponsored by our colleague on the committee, Mrs. Kennelly and Representative Boxer from California. This act provides Medicare coverage for mammographies screening on an annual basis and lifts the cap presently in the law. This is a very important step in encouraging mammography and making it more affordable for older women. I believe lifting the cap would create an incentive for women, perhaps, in those areas where mammographys cost more than $55, to get this vital annual service rather than creating a disincentive, which I believe the cap establishes in the law as presently studied.

Various services are recognized as a key element in reducing disability and lengthening life for older Americans. I believe both of these proposals should be implemented.

We will hear from witnesses today about the problem of financing the benefits provided under H.R. 2565. I know that this will be an area of great debate. Our experience with the Medicare Catastrophic Coverage Act of a few years ago reminds us coming up with mechanisms to finance additional benefits is always a most difficult task.

Mr. Chairman, I am looking forward to hearing from our witnesses today. I welcome Dr. Roper as an old friend of our committee. I thank you for having this hearing on these important measures.

Chairman STARK. If there are no further statements, Bill, why don't you begin to enlighten us in any manner you are comfortable.

STATEMENT OF WILLIAM L. ROPER, M.D., M.P.H., DIRECTOR, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ROPER. Thank you, sir. It is a delight for me to be before you and the committee again, Mr. Chairman.

I consider myself to be among friends. I appreciate that.

I would just say I am very appreciative of Mrs. Boxer. I don't think I have ever displaced a Congresswoman before, or Congressman. I am going to go real quick because I am going to tread lightly. Seriously, I am going to abbreviate my statement and make a few points.

First, I would say thank you for your recognition of the importance of prevention. I represent the Centers for Disease Control, the Nation's prevention agency, an agency of the U.S. Public Health Service. I am pleased to talk about prevention, but I understand that you are a receptive audience and I am glad for that. Prevention is an idea whose time has come.

I said to you April 16, 1991, when I was before the full committee, and I believe even more so now, that there is evidence all around us that the idea of financing preventive health services is a popular idea. I show you in the Washington Post where Blue Cross-Blue Shield National Association has made some important steps that will have implications for Blue Cross plans in the preventive services area. What they say is that the principal reason they are taking this step, or at least a principal reason, is that there is now a demand for preventive services. I think that is what you are witnessing as well in the constituents, the beneficiaries, the Medicare program.

But I am here today not only to say this is a popular program, a popular subject, but it is one that makes economic sense. You ought to consider including preventive services in the Medicare program not just because it is good for votes, but because it is good for the financial environment of the program.

I think we ought to judge preventive services on economic grounds, on cost-effectiveness grounds. One of the things we are doing currently at CDC is setting up a program to evaluate preventive interventions so that we can say not just rhetoric like "an ounce of prevention is worth a pound of cure," but so we can say that the costs are this much and the benefits are that much, and here is the concrete evidence.

Chairman STARK. Would you do me a favor? Would you have Mr. Darman in there while you make these decisions?

Mr. ROPER. Yes, sir.

Just a few things that have already been demonstrated. Cervical cancer screening among low-income elderly women yields a net savings of $5,900 and 3.7 years of life for every women screened.

A recent CDC study estimates the programs to reduce smoking during pregnancies saves over $6 for each dollar spent in the program.

As you know from many things Secretary Sullivan said, an emphasis of his throughout the Department these days is on prevention. That is entirely consistent with the subject that brings us here today.

I am a pediatrician. Pediatrics has been the most prevention oriented of the specialities. We have good examples from immunization and other areas of pediatrics. The challenge now is to consider the lessons we have learned well in pediatrics and see how we can spread them to all age groups in the population.

We have got to put these same talents, same techniques to work in other populations. We have got evidence there as well. For example, for women 50 years of age and older, screening with mammography and a physical has been associated with the reduction of at least 30 percent mortality from breast cancer. In addition, almost all of the nearly 5,000 deaths annually from cervical cancer could be prevented through early detection and treatment.

An estimated 45 percent of heart disease deaths could be prevented or at the least postponed through improved hypertension and control.

Nearly 400,000 deaths attributable to smoking each year are surely preventable in a cost-effective way. There is much in the "Guide to Clinical Preventive Services" that I know you have

before you that is relevant to this. It contains expert recommendations on what can be done in the prevention area.

I would just say that I applaud the committee's recognition of the potential for preventive services for all Americans, including beneficiaries of the Medicare program. We have got to get the message out that, for example, in smoking, it is not just targeted to teenagers, but senior citizens need to stop smoking as well. It is never too late to quit, never too late to undertake that and many other preventive interventions. We at CDC pride ourselves on our work in the prevention area, but we have only begun to make progress in this area, and would love to work with you and the committee in the future as we make prevention a practical reality for the whole Nation.

Thank you. I would be happy to respond to your questions.

[The prepared statement follows:]

TESTIMONY OF WILLIAM L. ROPER, M.D., M.P.H., DIRECTOR CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee, I am Dr. William L. Roper, Director of the Centers for Disease Control, the nation's prevention agency and an agency of the Public Health Service. I am pleased to have the opportunity to address this committee as a spokesman for the Public Health Service on the crucial role prevention plays in improving the health of our nation. Benefits of prevention include rewards from averting human suffering by reducing the amount of illness and disability, and in preventing premature death. In some cases, prevention interventions can provide a cost-effective alternative to other health care approaches. A few examples:

- o A study by Mandelblatt and Fahs in 1988 estimated that cervical cancer screening among low-income elderly women yields a net savings of at least $1,600 to $2,100 per person screened;

- o Each dollar spent on diabetes outpatient education saves $2 to $3 in hospitalization costs, and;

- o A recent CDC analysis estimates that programs to reduce smoking during pregnancy save over $6 for each dollar spent.

As Secretary Sullivan stated in his Foreword to Healthy People 2000, our country's blueprint for improved health, "Health promotion and disease prevention comprise perhaps our best opportunity to reduce the ever increasing portion of our resources that we spend to treat preventable illness and functional impairment."

Prevention's role in improving health across all age groups is becoming increasingly well-recognized, as evidenced by the first Surgeon General's Report on Health Promotion and Disease Prevention, which was published in 1979. However, historically prevention has not been high on the list of our health priorities for all age groups. Prevention efforts have been most consistently and, indeed most successfully, applied in the area of pediatrics. As a pediatrician, I look over the last forty or so years, and see tremendous strides made in improving the health of children. Through effective prevention measures, we have been able to eliminate polio as a major crippler of children in the U.S., and have, for the most part, left the devastating and lifelong effects of diphtheria, whooping cough, and tetanus behind us as a nation.

These successes did not come easily or quickly, nor did they occur without the concerted efforts of an array of institutions committed to protecting the health of our nation's children. Through the mutual resolve of parents, physicians and the public health community, we are working towards providing children with the best protection that medical science has to offer in preventing disease and disability.

We need to consider the lessons learned so well in the field of pediatrics and apply them more fully to our nation as a whole. We have seen prevention measures work for young adults, those in the middle years of life, and our elderly, initially through the leadership of the public health community, and now with the increasing cooperation of private health care providers. For example, significant progress has been made in public health against one of mankind's oldest enemies -- tuberculosis. Less than a century ago, tuberculosis (TB) was at the top of the mortality tables. Medical science - and practical preventive interventions -

have now severely reduced the impact of TB on our nation's population. While it remains a problem for some immigrant groups and for individuals infected with the human immunodeficiency virus, TB is no longer a leading cause of death in the U.S. Other diseases now top the charts as major killers - cancer, heart disease, diabetes among them. We have the tools to put prevention into practice against these diseases and other conditions:

- For women over 50 years old, screening with mammography and physical examination has been associated with a reduction of at least 30 percent in mortality from breast cancer. In addition, almost all of the nearly 5,000 deaths annually from cervical cancer could be prevented through early detection and treatment.

- An estimated 45% of heart disease deaths could be prevented or, at the least, postponed through improved hypertension control.

The nearly 400,000 deaths attributable to smoking each year are tragic given that these deaths are avoidable. Smoking by pregnant women is the leading known cause of low birthweight. It has been shown that for every $1 spent on smoking cessation programs for pregnant women, $6 are saved in neonatal intensive care costs and long-term care of ill infants. Opportunities abound for us to make a difference by effectively applying what we know about prevention to the diseases and conditions exacting the heaviest toll as we reach the 21st century.

Such opportunities are not just rhetorical. They are specific. The Guide to Clinical Preventive Services, produced by the U.S. Preventive Services Task Force, clearly set out a basic foundation of scientifically sound preventive practice recommendations. The Public Health Service is continuing to evaluate other specific clinical preventive interventions to supplement the Guide. In addition, the Office of the Assistant Secretary for Health has taken the lead in working to define age- and gender-specific packages (or "bundles") of services, with cost estimates for each age and gender group, to assist public and private sector policy makers considering the role of prevention in health care financing.

I applaud this Committee's recognition of the potential for preventive health services to benefit all Americans. Certainly, while prevention measures can well serve Americans of all ages, our needs for preventive services change as we move through life. America is growing older. People over age 65 make up about 12 percent of the population now. Their proportion is predicted to reach 23 percent by the year 2040. According to the Institute of Medicine's recent publication, The Second Fifty Years: Promoting Health and Preventing Disability, "Older Americans are currently given fewer cancer screenings than younger people, even though studies indicate that screening for cancer is at least as effective in persons aged 50-80 as in younger persons. Many older adults are never counseled to stop smoking, start exercising, or to take other life-saving measures commonly urged on the young, despite clear evidence that such measures help older people."

We spend nearly twice as much per person on health care as other developed nations. Yet, our life expectancy rate has slipped from 15th to 17th in the past five years. Of the $604 billion spent for health care in the U.S. in 1989, it is

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estimated that less than three percent was applied to prevention activities. There is growing recognition of the effective role prevention can play in improving our health. I have initiated a new effort at CDC aimed at identifying which prevention activities and programs work, which don't, and how to maximize the effectiveness of those that do.

The key is to take what we know about preventing disease and have it make a difference to the "man or woman on the street." People with hypertension need to know that they have hypertension. Women need to know that early detection is their best chance for beating breast and cervical cancer, and that mammography and the Pap smear work. Such knowledge is the first step -- but not enough. Once people have information, they need to use it to make a difference in their own health status; for example, by seeking treatment and followup for hypertension identified by abnormal test results.

With effective health education, people can make informed choices about behaviors and practices that will improve their health and help prevent disease. Individuals with diabetes can act on the evidence that weight loss and physical activity help reduce the need for medications with their adverse side effects. Our nation's young people, 3,000 of whom take up smoking each and every day, need to know that cigarettes kill, that they are not fashion accessories. They need the decision-making and peer-resistance skills available through comprehensive school health education that will enable them to avoid the temptation to smoke. Similarly, older Americans need to realize that it is never too late to quit. Quitting smoking increases life expectancy at all ages, and the increase for them, though less in the absolute number of years than for younger people, is proportionately as great.

Let me say in closing that, in the past prevention activities have largely been regarded as those taken when more urgent clinical crises are momentarily in check, when there is the luxury of sufficient time and money to educate on avoiding risk behaviors or to screen for diseases best checked through early detection. It is becoming increasingly clear that such activities, rather than serving as adjuncts to health care, should play a primary role in this nation's approach to improving its health. Prevention has proven itself in stemming illness and disability; we need to maximize opportunities to put it to work for us as a nation. One of my personal goals as Director of CDC is to make prevention a reality. CDC, in fact the entire Public Health Service, is committed to putting prevention into practice. I will be happy to take any questions.

Chairman STARK. Thank you.

Mr. McGrath.

Mr. MCGRATH. Dr. Roper, current law does not provide a mechanism for adding preventive services under Medicare. Consequently, the only way to provide those benefits through Medicare is through direct congressional action, as we did last year with mammography screenings on an every-other-year basis. In your view, do you believe the Secretary should be given authority to add preventive benefits under Medicare?

Dr. ROPER. Yes, sir, I do. It ought to be under a framework that is rigorous and that depends on scientific evidence of the efficacy and effectiveness of preventive interventions. Yes, we ought to have that.

Mr. MCGRATH. Let me ask you as a followup. You have given some examples of the cost effectiveness and cost benefit of preventive services. Do you believe as part of that discretion that we give to the Secretary that the services be proven to be cost effective before they are covered by Medicare?

Dr. ROPER. Yes, sir.

Mr. MCGRATH. Thank you very much.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Doctor, welcome to the committee again. The legislation before us recommends preventive coverage in four areas: Mammographies, colorectal screening, immunizations, and well-baby care. Where should we go beyond the four?

Dr. ROPER. What I suggest, and I should say that I spoke with Gail Wilensky, my good friend and colleague yesterday, many of these are technical Medicare areas that I am sure she would have an opinion on. For my part, I would say you need to set up a framework where, on a regular basis, just like coverage decisions in medical treatment areas, there is a process for studying preventive measures rigorously and then making coverage decisions.

There needs to be a similar process for preventive services so that you don't have to ad hoc your way along each time.

Mr. DONNELLY. You make no specific recommendation?

Dr. ROPER. I don't have a list for you.

Mr. DONNELLY. You don't have a laundry list of things from A to Z, in terms of priority importance to Medicare beneficiaries. Your recommendation on the process would be what, that it be decided internally within the Department?

Dr. ROPER. I don't want to make this up off the top of my head. Something like what you did, I guess it was in the fall of 1989, with setting up the medical guidelines process in the Agency for Health Care Policy and Research. There ought to be a process for studies to be undertaken and efficacy evaluations of those studies and public process for making coverage decisions flowing out of that. CDC would be pleased to be a part of such a process should you see fit to do that.

Mr. DONNELLY. The easy part is to advocate the coverage. The hard part is to pay for it. You would still leave the paying for it with us, I suspect?

Dr. ROPER. Yes, sir.

Mr. DONNELLY. We will be glad to give it to you if you want it.

Dr. ROPER. The difficulty—and you don't need me to tell you this, is that the savings from preventive services accrue in years downstream. It is hard to get those savings credited against the outlays of the current year. You didn't need me to tell you that.

Mr. DONNELLY. Thank you very much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

Nice to see you, Bill. If you have covered this, tell me. What do they do in other industrial nations with preventive services? Do you know?

Dr. ROPER. I am not extensively familiar with them. I think in most countries, if you mean Western industrialized countries, Europe mostly, they do cover more preventive services than we do here, in their health plan.

Mr. LEVIN. With your extensive and intensive background, what is the trouble here?

Dr. ROPER. It is the thing I summarized a minute ago. We have—and you daily grapple with this—the cost of the program. Additional incremental costs are difficult. You are going to be required to find a way to finance it. What people like me are trying to do is to sell you on some future gains to be had for the present pain of paying for these additional services. That is a difficult sell. Having said that, I would just portray for you the unfairness, that there is no similar test to be had for curative services within the Medicare program. Services are covered there whether they are demonstrated to be cost effective or not.

As the chairman said in his opening statement, you are living with the text of the law written in 1965. It didn't anticipate what we now face.

Mr. MCGRATH. I think one of the problems we face as a committee generally is that we do revenue projections, both cost and revenue enhancements based on a static basis rather than a dynamic basis that that shows some of these preventive measures saving money 10 or 20 years down the road. I think that is one of our major problems. When we get a cost of $100 million, we don't offset it against what the savings are going to be 20 years down the road. I think that is a major fallacy of the way we do things.

Mr. LEVIN. I think that is part of it. Part of it is the budget bind. Even when we didn't have such a bind, we were not undertaking these efforts. There is something in addition to it.

Dr. ROPER. If I could respond? What I would suggest is part of what you are getting at is that in this country, we have got, we have, or historically at least had, a real affection for dramatic curative treatments. We have given little to prevention. Even in my medical school career, and in most medical schools today, there is not much attention paid to prevention. It is something done in health departments and really without much regard to clinical practice.

Thankfully, we are bringing the worlds of public health and health care closer together. I hope we are going to be talking about prevention as something more than just things the Surgeon General and I do, but something that practicing doctors do in their offices day in and day out. Ultimately, payers will pay for it.

Mr. LEVIN. One reason I am a cosponsor of this bill is because I think we need to really yank ourselves on this. We continue to drift. We have known this for decades. Medical school curricula don't change. We have a big battle about mammography screening on the floor, when it is kind of mind-boggling that we are not providing this.

Just one vignette. Now, when we go for an examination at the House physician for glaucoma, at least in my case, I think it is true of others, they won't even trust their own equipment here. They ask you to go to Bethesda to be 100 percent sure. That is the kind of screening we receive. We don't devise a system that gives people the elemental screening on possible illnesses that are much more prevalent and in many cases, even more dangerous. I think there is a leadership vacuum. That is why I have raised it.

I think it is you and your generation—and you have had so much experience under your belt, if I might say so. It has to help lead us, and we have to do some of the leading ourselves to turn this around.

Dr. ROPER. I agree. Thank you, sir.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Welcome, Dr. Roper, especially for your contribution to this preventive initiative. What else would you recommend that we do to turn, to help turn around our system? What other places can pressure be put on the system besides Medicare and through the leadership by your office, the Surgeon General's, and I might also add the Secretary?

Dr. ROPER. As I said in my opening statement, I am not advocating that we just willy-nilly sell you all on covering everything that is deemed to be preventive. I think we need to have rigorous scientific demonstration of the effectiveness of prevention. I mean putting money into a permanent commitment to do evaluations of prevention measures. That will familiarize the bureaucracy and familiarize the scientific community with prevention as a continuing issue.

It will, I think, build a case in a very sound way for investing in preventive services so that you are not doing it just because folks back home in Connecticut are demanding it, but because you can cite this report, that study, and this analysis that says this is the appropriate thing to do.

Mrs. JOHNSON. Do you think that we are trying to change the system to better support family practitioners? Do you think family practitioners do any better job of prevention? Do you think the fact that they, in a sense, are the single case manager for the health of that person, that they play an important role?

Dr. ROPER. I don't know if you heard my advocacy piece for pediatricians. I hasten to say, family practitioners do much the same thing.

Mrs. JOHNSON. In a sense, the move toward management care ought to foster——

Dr. ROPER. If there is any place—and you have heard my advocacies for managed care before, but if there is any place where prevention stands a chance, it is in environments where health plans have an economic interest in keeping people healthy.

Mrs. JOHNSON. We do a sufficiently good job in Medicare of fostering managed care approaches, of encouraging that kind of approach.

Dr. ROPER. I have to take a pass. That is something I have not focused on for about 2 years.

Mrs. JOHNSON. Thank you.

Dr. ROPER. I was urging it 2 years ago to do more. Maybe you have. I haven't noticed.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you. I don't have any questions.

I would like to ask unanimous consent to submit a statement for the record. This is an issue that is very close to our family. I think you are aware——

Chairman STARK. Without objection, without reading the statement, I would request it be submitted into the record.

[The prepared statement follows:]

Statement of the Honorable Rod Chandler
on the
Medicare Preventive Benefits Act of 1991
June 20, 1991

Mr. Chairman, there is a growing consensus that the United States is in the midst of a crisis; that crisis being inadequate health coverage for American citizens. And that crisis is painfully reflected in the fact that 34 million Americans have no health insurance. In addition, skyrocketing health care costs now exceed 11 percent of our country's Gross National Product (GNP)and threaten to topple our current system under its own weight.

Those statistics have appropriately generated much concern, to which Congress has responded with any number of proposals to reform the country's health care system. And while I strongly support many of these efforts, I also believe there is much we can do within the context of our existing system to improve the health of American citizens. One such area is that of preventive health care.

Preventive health care saves lives. For that reason alone, Congress should be exploring new ways to promote this practice. With that goal in mind, I was pleased to join with you, Mr. Chairman, the Chairman of the Ways and Means Committee, Rep. Rostenkowski, and several other members of the Ways and Means Committee in introducing H.R. 2565, the Medicare Preventive Benefits Act of 1991.

In last year's budget bill, Congress appropriately included a provision to expand Medicare coverage for mammography screening. Such an expansion was long overdue. H.R. 2565 builds on last year's legislation by improving mammography coverage and extending it to equally valuable services such as colorectal screening, certain immunizations and well-child care. The bill would also extend an ongoing series of prevention demonstration projects, including a cooperative effort being conducted by Group Health Cooperative of Puget Sound and the University of Washington's School of Public Health.

I would also like to commend Rep. Boxer for her efforts in the area a preventive health care. I was pleased to add my name to a bill that she and several other members introduced yesterday that would provide for a more reasonable and realistic reimbursement schedule for mammography screening.

Clearly, Mr. Chairman, this legislation reflects a growing recognition among members of Congress of the value of preventive health care. But others have recognized its value, too. I would draw your attention to an article that appeared in yesterday's New York Times that reported the recent decision of the Blue Cross and Blue Shield Association to provide insurance coverage for a wide range of prevention and detection screenings. I am pleased that an insurer of the Blue's size and stature has recognized that preventive health care saves both lives and money. I commend their organization and urge their colleagues in the industry to consider similar changes.

Mr. Chairman, the legislation we are reviewing today will give a real shot in the arm to preventive health care. It promotes "wellness" through early prevention and detection screening. But perhaps its most attractive feature is the fact that it is easily implemented; in fact, from a practical standpoint, it requires no implementation at all. It merely requires a commitment from Congress to improve the health and quality of life for the citizens of this country. That alone should be sufficient to insure its passage.

Mr. Chairman, I commend you for your leadership on this issue and for convening this important hearing. I look forward to hearing the testimony of our witnesses.

Mr. CHANDLER. My wife is alive 13 years after discovering breast cancer and undergoing surgery and therapy. We can tell you what early detection means in the life of a very young woman at the time.

I want to commend our colleague from California, Mrs. Boxer, with whom I joined in sponsorship of a bill introduced yesterday aimed at the same purpose. Of course, I am joining you, Mr. Chairman, and the chairman of our committee, in sponsorship of the legislation that we are actually hearing today, H.R. 2565.

It seems to me that when we are seeing the private sector, as reported yesterday in the press, finding their way to funding preventive care as a means of reducing costs, Government certainly ought to take a lesson from that. It indicates to me that somebody has figured out, if you catch it early and treat it, you not only have healthier Americans and ones that live with their what previously were life-threatening diseases, but you also reduce the cost of health care.

Thank you.

Chairman STARK. Bill, I have a couple of questions. I have heard either through CBO or OMB estimates that only 20 percent of women who are eligible for Medicare will take advantage of this benefit. What would you recommend to raise that percentage? My suggestion would be that as a requirement for part B enrollment, every beneficiary must go through a series of preventive screenings so we would at least have a baseline figure? I'm not sure if this would be legal, but if it saves as much money as you suggest, maybe we ought to make it a condition.

Dr. ROPER. Never heard that suggestion. I am in the commission for the Public Health Service. I had to have an induction physical. Maybe you need to have that.

Chairman STARK. I don't know.

Dr. ROPER. It is worth thinking about.

Chairman STARK. Does that offend your conservative nature of keeping Government out of the public sector?

Dr. ROPER. No, sir. I think we can truly do a much better job of public education about the benefits of prevention. I think, to date, most of the demand for, for example, mammography comes from well-educated women, I would stipulate upper middle class, professionals, et cetera.

What we need to do is extend that demand for mammography and other preventive services to the general population.

Chairman STARK. Could you enlighten the committee a little bit on the difference between screening service and diagnostic service and the quality issue? What recommendations would you make as to how these services would best be provided?

Dr. ROPER. The question touches on one of the central points I was making. That is, you need to evaluate the cost-effectiveness of prevention. Screening services tend to be services that are done routinely at low cost for large numbers of people. Then you generate out of that a smaller population of people that need more intensive investigation.

Most people are familiar with screening chest x rays that we have had over the years looking for tuberculosis. A simple one kind of x ray test is done. Then, if something is found, a more detailed

series of x rays are done looking for specific lung lesions. In a similar way for mammography, there is screening mammography that is done relatively simply, generally at lesser cost for large numbers of women who don't have any symptoms, no pain, no lumps, et cetera, looking for evidence of lesions. Diagnostic mammography, on the other hand, is a more detailed, complex, thorough intervention that obviously would be more expensive. You need to make a distinction between that and whatever payment decisions you choose to make.

Chairman STARK. Which ones would you recommend?

Dr. ROPER. If you are going to do screening, you need to pay for screening as opposed to the diagnostic, more thorough kind of evaluation.

Chairman STARK. Are you suggesting we could do more screening?

Dr. ROPER. Yes, sir. Medicare now covers—I assume Medicare now covers—diagnostic mammography because it is necessary for the alleviation of a disease and disability, et cetera.

Chairman STARK. Could you comment on—I don't know whether we have heard from them, but I have a hunch that our friends in the radiology specialty would suggest that they do a better job and are more properly trained and better equipped to provide this service than are, say, general practitioners.

Can a pediatrician provide this service?

Dr. ROPER. I can't, no, sir, but, without avoiding your question too much, that is central to this point I have been trying to make to you. Those kind of questions need to be evaluated to see who can do, under what circumstances, cost-effective interventions.

Chairman STARK. As between the Physician Payment Review Commission, OTA, your office, and HCFA, should any one of them do it, or should all of them be involved?

Dr. ROPER. I am sure in your wisdom you will craft the right legislation. We would like to be involved. I say that strongly.

Chairman STARK. I want to thank you very much. Do any of my colleagues have any further questions?

Thank you very much.

I am pleased to welcome my colleague and neighbor from California, the Honorable Barbara Boxer, a leader in the crusade for preventive services for all people. Right now, it is for women. Proceed.

STATEMENT OF HON. BARBARA BOXER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. BOXER. Thank you, Mr. Chairman.

I have a statement I would like to put into the record, and it gets to some very specific questions you and I have talked about, about numbers and what it costs to give mammograms.

Rather than read from this statement, I think it would be better if I just talk to you all, first to thank you for what you have done for women's health. We had such a great breakthrough last year in making mammography a benefit through Medicare. It was a major step forward.

The reason I am here today is not only to thank you for that, but to essentially say now that we have made it a benefit, let's make

sure it works. Let's make sure there is not some artificial thing going on out there, namely, a cap which is perhaps stopping people from availing themselves of this benefit.

I sit before you, as I am sure—I shouldn't speak for my female colleague here, but I will speak for myself. I am a healthy woman. I have had a diagnostic mammogram in my life and a screening mammogram in my life. Let me assure you, they are the same thing in some ways. I just had this conversation with a female physician. The screening mammogram challenges even more because these things are settled sometimes. Whereas if there is a lump and you have a diagnostic test, you know where to look, what to look for. On a screening mammogram, you need to spend a lot of time where something could sneak through and a person could have breast cancer and not catch it for a year and die.

Our figures show 14,000 women died unnecessarily last year because they didn't get this mammogram. One in nine women is going to get breast cancer. Younger and younger women are getting breast cancer. What you do on this issue is crucial. My bottom line is that I am asking you to please consider and do—first of all, to look at Mr. Rostenkowski's legislation which would make this an annual benefit. I think this is very key, very important. Second, to lift this cap to treat the screening of mammograms as you do any other screening test. It doesn't cost the same thing in New York to get a mammogram as it does in Little Rock, Ark. There are different things that go into the fee. We are asking you to please treat this as you do any other type of screening.

Mr. Chairman, you and I talked about this yesterday. I confirmed it with your staff that indeed, this is the only screening exam that is capped. Maybe we women are being a little bit sensitive to this fact. I know you are getting information, but I will wait because I have something important to tell you.

Chairman STARK. Proceed.

Mrs. BOXER. Maybe we are being a little sensitive to the fact of the capping.

Chairman STARK. You are right. The cap is the only screening we pay for.

Mrs. BOXER. What about a Pap smear? That is important. This is just as important, is my point. Either we can change the Pap smear——

Chairman STARK. If the gentlelady would like to make her point?

Mrs. BOXER. That is my point. It is the only test that we cap. There is no difference between the two, the diagnostic and the screening, as I said before. And it is very important that we make sure, when we give a benefit, it is utilized. I think if you study it, you will find it is an impediment.

I got on the phone and called all over California, for example, and very few places charged the $55. They can do it if they have very, very heavy volume, but most don't have it. Most don't have the two machines.

So, I think what you will find is that we could do a lot by just making this benefit like any other benefit. The reason I am before you today is to try and persuade you to do that. I think it would be a very good thing that you could do for health care.

The point I tried to make when you were finding out some more facts was that women are a little sensitive to the capping, and you might say overly so, but we just went through this capping on the civil rights legislation, which you did not support. The fact is women's benefits are capped, women's rights are capped. It is getting to the point where, whether you agree with it or not, and we could disagree on this, we would like to see this uncapped and treated as any other screening exam.

I have lots of figures I could put on the table, if you want, or I could submit them, whatever is your wish, Mr. Chairman. That is all I have to say in my opening statement.

[The prepared statement follows:]

BARBARA BOXER
6TH DISTRICT, CALIFORNIA

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GOVERNMENT ACTIVITIES AND
TRANSPORTATION SUBCOMMITTEE
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COMMITTEE ON ARMED SERVICES

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TESTIMONY BY U.S. REP. BARBARA BOXER
Before Subcommittee on Health
June 20, 1991

Mr. Chairman, thank you for again allowing me to appear before you to discuss the issue of screening mammography and its importance. I commend you for your attention to Representative Rostenkowski's legislation to provide for annual coverage of screening mammography for women over 65. Breast cancer hits 1 out of 9 American women every year, and screening mammography is critical to its early detection and to saving lives.

I wholeheartedly support this bill and other legislation before Congress to mandate stricter quality standards for screening mammography. Today, however, I would like to once again look at the issue of Medicare reimbursement for this crucial test.

Last year, you were a pivotal force behind Congress' decision to add screening mammography as a benefit to Medicare, but costs were capped at $55 per test for all parts of the country. I am here to once again express deep concern about this cap.

Why is screening mammography, a test vital to saving the lives of women, the only procedure in Medicare to be capped? Even diagnostic mammography is reimbursed by Medicare on a fee schedule basis. I have had both diagnostic and screening mammography. The reason for the two tests is different, but I can tell you that the procedure, the equipment, the technician-- everything about both test procedures-- is exactly the same. Why is the reimbursement so different for two tests that are almost completely alike?

Is it because breast cancer is less of a threat to women than other diseases? Breast cancer is the second leading killer of women in America, and we hear every day of those who have the disease. Jill Eikenberry was on Capitol Hill yesterday to share her experience of overcoming breast cancer. Several of our colleagues have had breast cancer.

So why is mammography capped? Is it because screening mammography is not an effective procedure? Screening mammography is the only test available for the early detection of breast cancer. Experts agree that breast cancer death rates could be reduced by nearly 30% if all women followed the recommended guidelines for obtaining a screening mammogram. 14,000 women would be alive each year if they had a mammogram.

Knowing this, why do we put a nationwide cap on Medicare reimbursement for a screening mammography which does not adequately cover costs?

Last year, the GAO reported that over 50% of sites surveyed nationwide charged over $100 for a mammogram, 93% charged more than $50, and only 7% charged $50 or less. In our home state of California, where GAO surveyed 471 different sites, 52% of those sites charged over $100 and only 8% charged $50.

We know most places don't now charge $55 for a screening mammogram. Some places that offer low-cost mammograms are charitably subsidized, and some places that charge high fees are charging much too much. I join you in wanting to place limits on costs so that the test is affordable to women. But those limits cannot be below what it costs to offer the test. $55 is too low in very many settings.

It is obvious that it does not cost the same to provide a screening mammography in Little Rock, Arkansas or Jackson, Mississippi as it does in San Francisco or New York City. But the $55 limit fails to take into account these differences and treats all geographic areas, rural and urban, exactly the same.

Moreover, reimbursement at an inadequate level will not lead to greater availability of the test. Rather, it will lead to the development of a few centrally located, very high volume centers. Elderly women, and women who live far from a center, are likely to find the inconvenience of this system a barrier to compliance.

The other danger of limiting the reimbursement for screening mammography to only $55, is that it could also negatively impact women whose private insurance would pay for the test.

As you know, private insurance companies tend to follow Medicare's lead in setting a reimbursement cost for a screening mammogram. If the $55 limit is too low to cover costs in some areas, and if insurance companies also reduce their reimbursement to the Medicare level, then providers will not be able to afford to offer the test.

The key question, then, is what is the minimum break even cost in different areas? The only firm data we have are from the studies by the GAO and the PPRC (Physician Payment Review Commission).

The PPRC found that $50 was enough only in high volume settings. They then said that "at volumes of 15 to 20 exams per day, $50 is sufficient payment." However, if you look at their figures, they show minimum break even costs to be greater than $50 at these volumes, and break even costs that are higher still in high cost areas. Their own figures belie their recommendation.

More critically, there are two crucial omissions from the PPRC cost data. First, at volumes over 20-25 exams per day, two or more machines are needed. Second, the PPRC assumed a flat $12 payment to the radiologist. HCFA, however, mandated that the radiologist be paid 37% of the $55 cap amount, or $20.35. These two additions raise the volume amount needed to just break even at $55 to over 30 exams per day.

The GAO report listed the actual volumes of mammography achieved by the providers they surveyed. More than 97% of the providers did less than 35 exams daily, the break even point after these two adjustments. More than 89% did less than 20 exams daily, which is the unadjusted PPRC break even point. Clearly, $55 is too low in most settings.

Mr. Chairman, I urge you to consider removing the cap on screening mammography and to provide for normal reimbursement through a fee schedule. This action would go a long way toward making screening mammography more widely available to all women and would also treat this life-saving procedure in the same fair manner as all other Medicare benefits.

Thank you.

The following chart contains two adjustments to the PPRC analysis.

1. **The PPRC analysis only assumed one screening mammography machine. At higher volumes (over 25 per day, more than one machine is needed to handle the additional volume. The PPRC cost assumption for mammography equipment has been added in at volumes of 30 or more.**

2. **The PPRC assumed a flat payment of $12 per test for the radiologist fee. HCFA, in implementing the screening mammography benefit with the $55 cap, ignored this assumption and mandated that 37% of the fee go to the radiologist (for a total radiologist payment of $20.35. That is an additional cost of $8.35 per test, which has been added in.**

Suggested necessary additional costs:	5	10	15	20	30	40	50
A. Radiologist Fee	8.35	8.35	8.35	8.35	8.35	8.35	8.35
B. Additional Equipment					3.80	2.86	2.29
Baseline, Stationary	106.62	63.69	57.42	48.26	43.19	37.58	34.21
Revised Baseline Stationary	114.97	72.04	65.77	56.61	55.34	48.79	44.85
Average unadjusted	121.62	71.08	63.07	53.22	46.41	40.72	36.72
Revised Average Cost	**$129.97**	**$79.43**	**$71.42**	**$61.57**	**$58.56**	**$51.93**	**$47.36**

PERCENTAGE OF MAMMOGRAPHY PROVIDERS ACHIEVING SPECIFIED DAILY VOLUMES*

DAILY VOLUME	PERCENTAGE
Less than 5	34%
Less than 10	62%
Less than 15	79%
Less than 20	89%
Less than 30	96%
Less than 35	97%
Less than 40	98%

*Specified volumes combine both diagnostic and screening procedures. Screening only figures would be lower.

Source: GAO report HRD-90-32, January 1990, page 22. Data has been rearranged per conversation with GAO analyst Helen F. Toiv.

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Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you.

Thank you, Barbara, for your testimony. Thank you for your leadership on this issue. I just want you to know I couldn't agree with you more on what you have said. Government ought not be in the position of creating disincentives for people to take advantage of legal remedies which are provided by the government.

In some cases, whether it be in rural areas or in areas of high cost or areas where there is low volume, the costs of these procedures do exceed the $55 cap. The statistics I have indicate that 97 percent of mammography providers have volumes of less than 35 a day.

Thirty-five a day is the point at which you can actually hit the cap. To provide 35 a day, which would be one every half an hour, it would take 17 hours a day.

I wonder how many of these places are open for 17 hours. Those on a voluntary basis are the only ones who could achieve the cap. Any amount less than 35, and 97 percent of the mammography providers are less than the 35 per day, those providers would not be able to do the job for the amount of the cap.

My view on this is simply that we had an annual cost for this procedure done on an annual basis last year. It wasn't done for the every-other-year basis that we had in the bill last year. It was done on an annual basis. It was $100 million over the 5-year period.

It seems to me that all of us here were on the committee through 1984 to 1986, when $50 million—during tax reform—was an asterisk. That is what we used to consider. For $50 million, more than an asterisk, we can provide the leadership. This is what this bill does, it provides the leadership for the rest of the third-party payers to provide the kind of benefit that we all agree is important for women.

My view is that it is a little money for a great gain. As we pointed out in Sandy's colloquy with Dr. Roper, we often don't see the benefits of these kinds of preventive measures in the year that we incur the costs. Maybe it is 10 years down the road. Maybe it is 20 years down the road.

My view is that it is just a little money which is well spent for something which, in my view, not only could save lives, but save costs. I congratulate Barbara on your leadership on this issue.

Mrs. BOXER. Thank you.

If I might say, your point was so well taken. It was very exciting in yesterday's news that Blue Cross said they are ready to follow suit and for the first time, reimburse for mammograms. Your point is so on target, because they are going to follow Medicare's lead. If they only reimburse at a low rate, we are not going to get anywhere.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Barbara, you are very welcome. You are to be congratulated on your leadership on this issue, on mammography screening. I know on a personal basis what a strong advocate you have been on this issue. You are one of the people that literally forced the initial step that this committee took last year.

I think you make a good point. The chairman's bill is recommending a $55 cap and no assignment on mammography screening.

But a colorectal is based on a fee schedule and limits on balance billing. What is good for the—well——

Mrs. BOXER. I get it. This is a legitimate point. My recommendation is we put a flat fee cap on colorectal and unlimited balance billing, that they both ought to—whatever the committee does with this, and I don't know if the committee is going to move on this or what, and who is going to pay for it. I would strongly advocate that both screenings be treated the exact same way.

I am very concerned when you have no limit on physician billing, and that this committee has heard me say this for a decade, and you have an arbitrary $55 cap, that the great expense will be paid out of the pocket of the elderly beneficiary, which will be a disincentive for those people, most especially the poor elderly, from going to get this type of service.

It is frightening to hear that it is projected that only 20 percent of the Medicare beneficiaries would take advantage of this if it was provided. That is a frightening statistic. I think there is a lot of education that needs to be done.

I would suspect if it is only 20 percent, if we don't put some cap on the cost of this, that will even reduce it further and will get us to the point where we really don't want to be, in terms of a negative return on a very high investment out of pocket for the beneficiary.

The gentleman points out the colorectal is another screening procedure that Medicare pays for; is that correct?

Mr. DONNELLY. That is in the Rostenkowski bill.

Mrs. BOXER. It would become the third screening benefit.

Chairman STARK. It is capped.

Mrs. BOXER. Mr. Donnelly says it is not capped. I was going to ask about that.

Mr. DONNELLY. It is based on a fee schedule.

Mrs. BOXER. It is based on a fee schedule.

Mr. Chairman, it is definitely gender-neutral. I am trying to find out if it is capped, because Mr. Donnelly said it is a fee schedule. We are asking mammograms be treated the same way.

Mr. DONNELLY. Irrespective of one way or the other, they both should be treated the same way. This committee will have to decide which way we treat them.

Mrs. BOXER. I understand. That would be at least a fairer way. Let me just say we all have elderly aunts and moms and grandmoms and the like. Initially, when this came out, a lot of us thought we will have these screening mobiles that go around. But the thought of some of our elderly grandparents and parents, it is difficult to get them to do that. They won't do it. If they have an easier setting they are used to, they will. It may cost them more. There is no question about that. That is the chairman's dilemma, I understand.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I welcome you also, and your leadership. I don't have much to add. I think Mr. Donnelly kind of summed it up. We are going to have to find a way to control costs, but do so in a way that encourages services. There is no use of our trying to turn this around and have preventive medicine really getting a hold in this country and then put a cap on payments that undermine it.

I am in favor of radical surgery here to try to turn our focus around, because, as we discussed with Dr. Roper, it just doesn't make any sense. I think there is a vacuum of leadership here.

You have helped to fill it. I hope we will really move on it.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I just want to welcome the gentlelady from California and thank her for her leadership on this issue. It has made a difference. The strong and persistent voices out there have brought to the Nation's attention the importance of mammography, not just as a reimbursable preventive health service, but as something women must do for themselves.

I don't believe that we can be surprised that the percentage of the Medicare population that is going to take advantage of this is rather low. I think our goal should be to get those early retirees in the habit, that is our aim.

There are a generation of women—my 93-year-old mother included—who wouldn't think of being willing to submit herself to this for a whole lot of reasons, nothing to do with whether she thinks she is going to get cancer. This is a habit we must form. It is only one in a series of habits, including abstinence and exercise, that our society needs to develop.

Chairman STARK. Celibacy, I said.

Mrs. JOHNSON. It is really welcomed, the time you have taken to be here today. I think this committee is strongly behind your proposal, including treating it like any other service. Thank you.

Mrs. BOXER. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. I want to echo my comments. I hope we don't characterize the cap as something of being punitive to women. When we created the benefit last year, I would have resented it if somebody said you singled out women to create a benefit for them.

I don't recall anybody suggesting such a thing. Now, in discussing whether to remove the cap, I think that is an issue. Does it make sense? I think this is much more a gender-neutral issue than perhaps you may have characterized it.

Mrs. BOXER. I am just telling you what people are saying. Not that it was thought of at the time, but it is just happenstance that it is the only screening procedure that is capped. It is happenstance. We need to look at whether it is working.

If it is working beautifully, there is no need to mess with something that is working.

Mr. CHANDLER. That is why we need to look at it.

Mr. LEVIN. Would the gentleman yield?

I think there is a cap that was part of a compromise to pass it.

Chairman STARK. To keep the cost down.

Mr. LEVIN. It gets back, I think, to the point, we need to face up to this issue and be willing to bite the cost bullet, because if we let cost, as you were saying, Ray, superficially guide this, the immediate buck, we are never going to do this.

Mr. CHANDLER. When we work so hard on this committee to get this benefit included, the cap certainly wasn't aimed at any gender.

Mrs. BOXER. No, it was agreed to by all of us. We were part of the compromise. Remember Mary Rose? We agreed to it. Now we are saying let's look at it.

Mr. Chairman, if I might place into the record some of the areas where we have contacted to get ranges of what Illinois, Georgia, California, Mississippi, South Dakota and Maryland——

Chairman STARK. Let's compare. What are your numbers?

Mrs. BOXER. In Illinois, we show ranges from $61 to $140.

Chairman STARK. You have to expand your range. Cook County Clinic in Chicago is free. Add that into your average. Another example is Grant Hospital in Chicago where the fee is $50.

Mrs. BOXER. Charitable is a different situation.

Chairman STARK. Where else?

Mrs. BOXER. Generally, as I say, the average is—the average actual under Medicare is $70 for the diagnostic. For the screening—well, interesting, in California, they are not paying for it yet because it wasn't licensed. There could be no average.

Chairman STARK. To the Chair's best recollection, this committee does not, and it would be the Chair's intention to suggest that it will not get into discussions of pricing procedures. We are advised, and I think well, by several groups, the Physician Payment Review Commission being our principal technical adviser, shared by Dr. Phil Lee, formerly head of the medical center in San Francisco. He is acknowledged to be a competent physician and expert in public health. Also, the OTA aids us along with professional groups; for example, a radiologist who, at least to my knowledge, found no objection to the $55 rate. Arguably, they would like more. I think I can state without fear of contradiction that they agreed that is a rate they could live with.

If we were to do this today under present law, there would not be a cap, but there would be a relative value fee established. The reason there is a cap is that when we repealed catastrophic, we promised to bring these benefits back. We promised that for perhaps budget and procedural rules, that we would bring the benefit back precisely word-for-word the way we passed it at catastrophic. That was the deal. To do that, we had to go back under the law prior to our passing the physician reimbursement bill which is in effect now.

If, in fact, the cap were removed, and this is an interesting—if the question is going at the cap, it is simply going to be to change the name. I am advised that the cap would go because it increases at 4.1 percent a year over by $66 to $63.45. The cap goes to $57.25. RBRVS goes to $64.45. The cap will go to $57.25 and the RBRVS will go to $55.20. The price will go up higher if the cap is left where it is then having it revert to the RBRVS.

If the object is to get more money to the physician, the cap is going to go up faster than incorporating it into the reimbursement system. That is not to suggest that the Physician Payment Review Commission wouldn't at some point decide a doctor ought to get more or less for this. It is not really within this committee's purview to suggest what can we do to get more people to participate.

There isn't much budget cost. It is somewhat a matter of indifference to the Chair as to which way we go. It isn't going to change pennies of the $55 charge very much. The practical effect is that

for those people concerned about access, it is my understanding of the law that if a physician is a participating physician, he or she must, by law, provide the service at the Medicare rate.

So that if, in fact, you are concerned about a rural practitioner, if that practitioner participates, then he must in fact provide the service. While the range we have found, some people are charging $95 even in San Francisco and this area, there are a lot of people who are in the $45 to $55 range.

I don't think our changing the rate of taking the cap off is going to make any difference. You will still have some people who will stay $190. They have to decide whether to provide the service. We can't make them provide the service.

Mrs. BOXER. Let me just respond.

Chairman STARK. I am confused as to the concern. If it is not to call it a cap——

Mrs. BOXER. That isn't it, Mr. Chairman. Come on. We are buddies here. I just want to see that this benefit works. I don't care if a physician is poor or rich. I don't care about that.

Chairman STARK. The benefit works if people participate.

Mrs. BOXER. I want people to use it, and I want it to be reasonably priced so when the private sector follows suit, this becomes a benefit that will be utilized. We are all in this for one reason: Prevention. We want to stop people dying from breast cancer.

When I see a GAO survey that says 8 percent of the settings in California charge $50, 56 percent charge over $100, we have a problem. I am not telling you how to fix it. I don't know.

Your staff told me yesterday people don't have to take assignment on this, that they are not forced to.

Chairman STARK. No, they aren't. I didn't say that. Doctors who participate—and about half of the physicians of the United States participate—it means those physicians must provide all Medicare services at the Medicare approved charge.

Mrs. BOXER. Including a mammogram.

Chairman STARK. Or any other at the Medicare rate. The doctors may take assignment. They do that voluntarily. Those who take assignment can charge no more than the Medicare rate. Those who don't want to don't have to provide it.

The issue that I would submit is that most people under Medicare don't price services. Seventy percent or more of the Medicare beneficiaries have supplemental insurance which will pick up the difference that Medicare doesn't buy.

What we have found is that Medicare beneficiaries have no concept of what their services cost. They go and get the service, and they don't pay the bill. The issue of what is charged has not been an access issue with Medicare. It is relatively, I would think, a matter of indifference. I think more likely is the convenience. Maybe these trailers aren't seen. I rarely hear of Medicare beneficiaries who don't get a medical service because it costs too much.

Mrs. BOXER. I would respectfully disagree with you. When my mother was alive, she said Medicare is covering less and less. Then she had some other insurance, and she never somehow did it. Yes, it was costing her out of pocket. Yes, it upset her. Yes, it was hard on her.

I think the very wealthy Medicare recipients, they don't care about it. I think the poor to moderate——

Chairman STARK. My feeling is that——

Mr. MCGRATH. Would the gentleman yield?

I think we are missing the point. You are talking about access. You are talking about increasing the fee to the physician. I am talking about creating a fee or a regionally adjusted fee that will increase an incentive for a woman to get it. If you can't get it in a rural area because the volume is so low that it costs $150 for them to do it, then it won't get done.

If they live in Valley Stream, Long Island or in Cook County, in Chicago, the taxpayer pays it. But it is not free at the Cook County Clinic. Somebody is paying for it.

Chairman STARK. If I could reclaim my time, the Medicare beneficiary—you could properly state, and even I would not be so suspicious of physicians, that if we paid more, doctors would get out and promote this in exchange for money. I don't think the Hippocratic oath encourages that. Beneficiaries don't price anything.

Mr. LEVIN. Just quickly, so we are just looking at the charge here. The switch from a cap to the RBRVS system could have some significance. The RVS system takes into account the practice, the regional variations, et cetera, practice differentials and the like.

Chairman STARK. The gentleman is absolutely correct, if he would yield. It would run from $47 to $63.

Mr. LEVIN. Still, I think everyone accepts those services—I think everyone accepts any new service is going to have to come within a cost structure. I think the point is——

Chairman STARK. If the gentleman would yield further, this isn't a new service. We are paying for it for the first time. The service has been around for a long time.

Mr. LEVIN. I meant in terms of coverage.

Mr. DONNELLY. Statistically very few of our beneficiaries took advantage of the service.

Chairman STARK. Correct. They will take advantage if a physician tells them to go, or if there is a public education volunteer.

Mr. LEVIN. No. We have a major obligation to undertake preventive services as we are doing with smoking and other health problems. We can't just say let it work out there without trying to shape attitude.

Chairman STARK. What I am suggesting is there is no indication yet that services are being denied or access is being limited. If there were, I think the committee would move rapidly to change that. These services are available. Medicare patients are neither being turned away nor are they denied service.

In California, the bills aren't getting paid because they have not licensed the screening procedure in the State yet. Diagnostic tests are paid for at a slightly higher rate, $70.

Mr. LEVIN. Thank you for yielding.

Chairman STARK. I would just like to assure the gentlelady that, as has been stated, there is no intention here to discriminate in any way on a gender basis of what tests are paid for.

Second, the committee would be vitally concerned if they thought services were being withheld or access denied. I am not sure that changing the cap to an RBRVS will do that, one way or another.

We will, I am sure, receive testimony from the radiologists and from the family practitioners and from the Physician Payment Review Commission as to what is a reasonable rate to pay, as we do with every other procedure that Medicare pays for. I would be happy, and I am sure the committee would, if we could dream of any way to encourage more people, it might make it a condition.

Mr. DONNELLY. I think that is a good idea. Would the gentleman yield?

I do think there is a perception point here that I think all of the screenings should be reimbursed in the exact same manner. That is my objection to the chairman's bill.

Chairman STARK. Not this chairman. The big chairman.

Mr. DONNELLY. I think everything should be treated the same, whether we adopted a cap for colorectal. We can go that direction, too. Whatever we decide, it should all be the same.

Mrs. BOXER. I think that is a reasonable point. I want to thank the chairman. He and I discussed this for a long time.

Chairman STARK. Our next witness is Dr. Roger Herdman of Health and Life Sciences Program at the Office of Technology Assessment. Welcome to the committee, Doctor. Please proceed to enlighten us.

STATEMENT OF ROGER C. HERDMAN, M.D., ASSISTANT DIRECTOR, HEALTH AND LIFE SCIENCES DIVISION, OFFICE OF TECHNOLOGY ASSESSMENT, ACCOMPANIED BY JUDY WAGNER, SENIOR ASSOCIATE

Dr. HERDMAN. I am accompanied by Judy Wagner, a Senior Associate from the Office of Technology Assessment. I am going to summarize my remarks, with your permission, having submitted a statement for the record.

I am Assistant Director of the Office of Technology Assessment. My testimony is from the Office of Technology Assessment, representing that Office's work and our views.

Mr. Chairman, I think this legislation that we are considering today is based as solidly as any I know on informed public health and medical opinion and published scientific work, including work done by OTA for this subcommittee.

At the request of Congress and most frequently, in fact, at your request, OTA has submitted reports on almost all the preventive interventions contained in the legislation being considered. As you know, we have testified before you on several occasions in the past about certain of these specific benefits.

Your interventions also find support in the findings of the U.S. Preventive Services Task Force, the Canadian Task Force, the guidelines of the American College of Physicians, and just recently, in the coverage recommendations of the National Blue Cross and Blue Shield Association, which in fact today the subcommittee has asked OTA to take a look at.

We will be happy to do that and get back to you as quickly as we can with our review and with our comments on that, probably in a letter form.

Chairman STARK. You are talking about the recommendation of the Blues?

Dr. HERDMAN. Yes, sir.

Chairman STARK. If I could interrupt at this point and point out to my colleague from Massachusetts, Blue Cross-Blue Shield just announced they were going to cover preventive benefits. I have asked OTA to review the items in that package. I am informed that the Blue Cross benefits are just catching up to what we already offer.

I just say that to remind the world that Medicare is one of the best reimbursement insurance programs in the world, and it is nice to be ahead. Is that a fair assessment of what you responded to?

Dr. HERDMAN. If the bill under consideration were to become law, Medicare benefits would be closely tracked by the recommendation. I might say these are recommendations. They are not necessarily implemented by all Blue Cross-Blue Shield plans across the country. They are well thought out recommendations by the National Blue Cross-Blue Shield. They are essentially identical with the provisions for your legislation.

Chairman STARK. Which is to say great minds move in the same direction.

Dr. HERDMAN. I would be the first to congratulate you on that.

Chairman STARK. Praise us on any other matter you might like.

Dr. HERDMAN. I would bring to your attention, Mr. Chairman, that many of the concepts, our concepts, are reviewed in the February 1990 report on policy and research issues, which we prepared at your request. Among other things, it points out some of the weaknesses in existing data which supports the need for continuing demonstration projects which are, as you know, a feature of your bill.

Also, this publication contains short summaries of the OTA reports on preventive technologies completed to that time, which might be useful to you, and it provides a survey of screening technologies, a literature review and so on, which is very similar in many ways to the survey review which the American College of Physicians recently issued to form the basis of their guidelines as reported in the Annals of Internal Medicine.

Let me close by making a few short comments concerning the specific benefits which are contained in today's legislation.

These are either cost-saving or cost-effective within the range that Congress has previously found to be acceptable. For mammography screening for breast cancer on a biennial basis—the current benefit—there is a cost of $24,000 per year of life saved. We estimated something like 64,000 late-stage cancers would be detected in that population over the next 30 years. For annual mammography, the cost would be $35,000 per year of life saved, and an additional 21,000 late-stage cases, or essentially deaths, would be detected or essentially prevented in the population.

You should consider that as comparing the benefits to nothing. There is a marginal difference between biennial and annual which amounts to about $65,000 per year of life saved, because you get a little bit better bang for your buck on the biennial than the annual.

However, if you wish to save those 20,000 lives, clearly you are going to have to go to an annual screening. You have made that decision.

Colorectal cancer is within the same cost-effective range. That is for fecal occult blood testing on an annual basis, $35,000. And for flexible sigmoidoscopy on a 5-year repeating basis, $42,000 for a life-year. The lives saved in a cohort of people entering the Medicare program at age 65, 22,000 for the fecal occult test as that cohort moves through. An additional 10,000 with the added sigmoidoscopy.

Childhood immunizations are one of the best preventive technologies in terms of dollars and cost saving. It is as good as it gets, basically. We have studied this in a report which we issued called "Healthy Children." That report suggested that the well-child visits be done with the immunizations since the evidence for benefit from well-child visits is less than overwhelming in the literature, and most of the value of visits is based on informed medical opinion rather than actual clinical trials.

OTA also looked at influenza vaccine on an annual basis. This is a cost-saving intervention and something which is clearly overdue. Tetanus is not a common set of disease in the Medicare population, but something which is well worthwhile.

May I close by saying that you requested a study subject to approval of OTA's Board in the legislation to look at language which would—could be used to get the Secretary to include preventive technologies on a regular basis routinely. I am very optimistic that we will be able to work closely with you and perform such a study in the future.

Thank you very much, Mr. Chairman, for the opportunity to appear before you.

[The prepared statement follows:]

TESTIMONY OF ROGER C. HERDMAN, M.D., ASSISTANT DIRECTOR
OFFICE OF TECHNOLOGY ASSESSMENT
U.S. CONGRESS

BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

June 20, 1991

COVERAGE OF CLINICAL PREVENTIVE SERVICES UNDER MEDICARE

Mr. Chairman, I am happy to provide testimony today on an important issue for health policy: coverage of clinical preventive services for Medicare beneficiaries. As you know, over the past 10 years, the Office of Technology Assessment (OTA) has conducted a number of studies of the effectiveness and costs of selected preventive services. Today I will use what we have learned in conducting those studies to comment on the legislative proposals under consideration by your Committee.

Current Status of Medicare Support for Preventive Services

As the primary source of health insurance for the nation's 32 million elderly and disabled individuals, Medicare provides access to a wide range of health services for diagnosis, therapy, and rehabilitation. Yet, Medicare is prohibited by law from offering benefits for preventive services except when they are specifically added to the list of covered benefits through amendments to the Medicare Act. So far, Congress has legislated expansions of the Medicare benefit to include Pap smear screening for cervical cancer, biennial mammography screening, and pneumococcal pneumonia and hepatitis B vaccines.

Decisions to expand Medicare to cover preventive services are not easy, because the potential costs associated with such services are often high, and the potential benefits are largely uncharted. There is little information, for example, about whether periodic health checkups actually improve the length or quality of life of the elderly. Although substantially more information exists about other preventive services, in every area that OTA has examined, we have found some uncertainty about the potential medical benefits and risks of the procedures. For example, though we concluded that mammography screening is effective in reducing mortality from breast cancer in elderly women, the information on which we base that conclusion comes from studies of younger women and is extrapolated to older age groups. The same is true for Pap smears. Faced with uncertainties of this kind, OTA has used its best judgment in estimating the effectiveness, risks and costs of selected preventive services under consideration today. Our main conclusions follow:

Well Child Care and Childhood Immunizations

Well-child care encompasses two main aspects of prevention: immunization (administration of vaccines) and health supervision (physical examinations, screening tests, health education and parental guidance). These are generally integrated in a series of scheduled visits.

Childhood immunizations are the brightest examples of the power of prevention to promote health, save lives, prevent significant disability, and lower medical care costs. In a study of children's health, OTA concluded that the immunization schedule recommended by CDC's Immunization Practices Advisory Committee (ACIP) is an effective and even cost-saving health service for young children (OTA, 1988). The ACIP currently recommends six to seven visits between the ages of 2 months and 16 years for immunizations against eight diseases: polio, diphtheria, tetanus, pertussis (whooping cough), measles, mumps, rubella, and haemophilus influenzae b infection (table 1). The pertussis vaccine alone prevents more than 92,000 cases over a six year period for every 1 million children immunized and pays for itself in savings in lifetime medical costs for those children (Hinman and Koplan, 1984; OTA, 1988).

While immunization works well, the evidence on child health supervision is much more equivocal. None of the studies we examined supported the contention that child health supervision of normal risk children significantly influences either mortality or morbidity or that it enhances the development of a child's social or intellectual competence. On the other hand, the

studies have all been too small and follow-up too brief to identify modest mortality impacts, and the available measures of developmental outcomes are inadequate. Certain specific screening tests, such as those for vision, hearing, and iron deficiency anemia may be effective in detecting important problems early, but there is no good evidence on how frequently such screening should take place (OTA, 1988; Wagner, Herdman and Alberts, 1989).

It is worth noting that the U.S. Preventive Services Task Force, which recently issued guidelines for physicians based on a review of the effectiveness of well child care, concluded that "...the scheduling of additional visits [above the ACIP schedule] is left to clinical discretion" (U.S. Preventive Services Task Force, 1989). The Task Force did recommend yearly screening for children at high risk of lead poisoning.

Given the uncertainties about the effectiveness of health supervision, a benefit package that combines immunizations with health supervision in visits that coincide with the ACIP schedule appears to be a reasonable approach that would encourage immunizations, gain whatever unmeasured benefits there are in health supervision, encourage parents to find a medical home for their children, and save health care costs. It is important to keep in mind, however, that Medicare children are likely to be quite atypical with respect to health status and medical risks. Disabled children may benefit from special interventions that go well beyond the traditional concept of well-child care. Discretion is certainly in order in interpreting preventive health needs in this particularly vulnerable population of Medicare beneficiaries.

Mammography Screening in Elderly Women

Despite advances in detection and treatment in recent years, breast cancer remains a common disease of American women, and a virulent one in medical, emotional, social and economic terms. Breast cancer is a disease that primarily afflicts older women. In 1987, about 48,000 new primary cases of breast cancer (44 percent of all new breast cancer cases) occurred in women over age 65 (Health Technology, 1987).

In 1987, OTA contracted with Dr. David Eddy to estimate the cost-effectiveness of annual and biennial breast cancer screening (consisting of breast physical examination and mammography) in women 65 years of age and older. The results of that analysis, reported in OTA's 1987 study of Breast Cancer Screening, (OTA, 1987) indicated that, compared to no screening, biennial breast cancer screening in women between 65 and 74 years of age could prevent almost 64,000 cases of late-stage cancer by the year 2020[1] at a cost of approximately $24,000 per year of life gained.[2] Compared to no screening, annual breast cancer screening in women at the same age would prevent 85,000 late stage cancers by 2020 at a cost to Medicare of $35,000 per added year of life.[3] Thus, compared to doing nothing, either biennial or annual breast cancer screening appears to buy significant health care benefits at a reasonable cost.

As you know, biennial mammography screening is already a covered Medicare benefit. The appropriate question for Congress now is how much additional benefit would be gained from enhancing the benefit to include annual rather than biennial screening. The annual screen would prevent an additional 21,000 cases of late stage cancer by the year 2020, but these

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1 This estimate assumes that 30 percent of elderly women will comply with the mammography screening schedule.

2 All estimates of cost per year of life gained were computed by discounting both costs and health effects to their present value in 1987 at a rate of 5 percent per year.

3 This analysis assumed that screening mammography would be reimbursed at $50. In a more recent analysis that was not restricted to Medicare costs, Dr. Eddy estimated that an annual breast cancer screen in women 65-75 would cost between $17,500 and $42,000 per year of life added, depending on assumptions about the effectiveness of breast cancer screening. (Eddy, 1989) Eddy assumed that breast cancer screening itself would cost $100 ($25 for clinical examination and $75 for mammography). OTA computed the range given above from data provided in Eddy, 1989.

health benefits come at a higher cost. The incremental cost per extra year of life gained as a result of moving from biennial to annual mammography would be about $65,000 per year of life gained.

These estimates are based on substantial uncertainty about the magnitude of medical benefits of mammography in older women. We are particularly uncertain about the additional health benefits that accrue from annual mammography. Some recent analyses suggest that breast cancer may progress more slowly in older women, which would mean that fewer additional cancers would be found in annual screening than we have assumed (Brown, 1991).

Colorectal Cancer Screening in the Elderly

Cancer of the colon or rectum (colorectal cancer) is primarily a disease of the elderly. Every year, about 110,000 people age 65 years of age and older are diagnosed with colorectal cancer. Almost 3 out of every 4 new cases of colorectal cancer occur in the elderly. The best potential at present for reducing the threat of colorectal cancer is through screening procedures that detect cancers in early and still curable stages, or even prevent cancer by detecting their precursors -- benign adenomatous polyps.

The most common technologies for screening for colorectal cancer are the fecal occult blood test (FOBT), which analyzes samples of stool for the presence of blood, and flexible fiberoptic sigmoidoscopy (FSIG), an examination with a flexible tube that is inserted into the colon and permits the physician to inspect the interior of the rectum and part of the colon. FOBT is an inexpensive laboratory test with a Medicare fee of about $4. Sigmoidoscopic examinations cost Medicare about $100.

In a recent study completed for your Committee, OTA examined the costs and effectiveness of alternative colorectal cancer screening strategies. One strategy is to screen people annually from age 65 to 85 with FOBT only. Other strategies combine annual FOBT screening with periodic sigmoidoscopy. (We looked at screening with sigmoidoscopy once at entry to Medicare, every five years, and every three years.) OTA estimated that the lifetime cost (expressed in present value terms) of screening, followup and surveillance for a person who starts a program of CRC screening with both FOBT and sigmoidoscopy at age 65 ranges from $750 to $940, depending on the frequency of FSIG. Annual screening with FOBT alone would cost about $372 per person over the course of their remaining lives (table 2).

At any one time, elderly people of various ages would be undergoing CRC screening, so OTA also calculated the annual net cost to the U.S. health care system associated with screening, followup and surveillance of all people in any year (measured in 1988 dollars). Costs would vary from year to year as the effects of starting up a program wear off and as the age-distribution of the elderly population changes. They also depend on rates of compliance with the screening regimen. For example, if a Medicare benefit for FOBT or FSIG were used by 20 percent of the elderly population, the estimated annual cost of screening after 9 years of operation would be between $440 million and $500 million for screening with FOBT and FSIG, and about $240 million for FOBT alone.

This investment should produce dividends both in terms of longer healthier lives for the elderly and savings in health care costs, although at present there is no definitive evidence that colorectal cancer screening does alter mortality. We constructed a model of the cost-effectiveness of periodic screening from 65 to 85 years of age. We made very pessimistic assumptions (i.e., biased against finding in favor of screening) about the accuracy of screening, the speed of progression of polyps to cancer and cancers from early to late stages, and other characteristics of the disease about which we were uncertain. We found that compared to no screening, any of the CRC screening strategies delivers an additional year of healthy life for no more than $50,000 (table 3). Annual FOBT is the most cost-effective strategy. It buys an additional year of life for no more than $35,000. (Since we were conservative in out estimates of effectiveness, the true cost is probably lower). This is less than the additional cost per year of life gained from annual mammography screening in elderly women (OTA, 1987).

The decision whether to provide FOBT only as a Medicare benefit or whether to combine FOBT with FSIG at a certain interval should be based on the additional health benefits achieved by FSIG over and above the FOBT and the additional costs of FSIG. Our model cannot give an accurate picture of the incremental cost-effectiveness of FSIG screening, because it is very sensitive

to assumptions made regarding one aspect of the disease about which there is virtually no good data: the speed with which polyps and cancers progress to more lethal stages. The slower the progression rate, the less cost-effective will be adding FSIG to the screening regimen. While FSIG picks up additional cancers, if such cancers grow slowly, they would have been more likely to be picked up in early stages in subsequent FOBT screens. Also, FSIG is so sensitive that it will pick up many polyps that would not have grown large and progressed to cancer, which will be treated with some cost and risk. If colorectal cancer progression rates in the elderly are very low, the incremental cost of sigmoidoscopy per added year of life could much higher than the cost of preventive services currently covered by Medicare. In light of these uncertainties, OTA concluded that while annual FOBT screening in the elderly is at least as cost-effective as annual mammography screening, the same cannot be said for FOBT in combination with periodic sigmoidoscopy.

Influenza Vaccination

Influenza vaccines are reformulated with each influenza season because influenza virus strains change over time. Consequently, the effectiveness of influenza vaccination will vary depending on how well the vaccine formulated in any year matches the viral strains that actually arise during the season. OTA analyzed the cost-effectiveness of the influenza vaccines administered in the 1972-1978 period (OTA 1981). We found that the influenza vaccine administered to the elderly was cost-saving in that period. For other groups of the population, the influenza vaccine did not save health care costs but in high-risk groups was very inexpensive for each healthy year of life gained. These findings are consistent with the recommendations of the ACIP, which calls for annual vaccination of all people 65 years of age or older and of children and adults who are at increased risk for influenza-related complications.

Tetanus-Diphtheria Vaccine

OTA has not studied the Tetanus/Diphtheria vaccine in adults, but the contribution of the vaccine to the dramatic decline in the incidence of these two diseases has been well documented. Only about 90 cases of tetanus 60 cases of diphtheria have been reported annually over the past decade (Immunization Practices Advisory Committee, 1985). Medicare coverage of tetanus/diphtheria vaccine on a 10-year schedule for adults of all ages could have little further effect given the current low incidence of the diseases, but Medicare would be assuming the cost and ensuring the application of a clearly highly effective and probably cost-saving technology.

Need for Additional Research

In conducting work over the years on preventive services, we have been struck by the inadequacy of data on the effectiveness of clinical prevention in altering outcomes for the elderly. The importance of the subject to older people argues for a commitment to greater research on what kinds of prevention are most effective in this population. The Health Care Financing Administration is currently supporting six Congressionally mandated Medicare demonstration projects that offer preventive health services to Medicare beneficiaries. Because of inadequate funding and short followup times, these projects as they are currently configured are unlikely to provide much new evidence on effectiveness. To get more information from the studies already underway, it makes sense to extend and increasing funding for some of them to allow for collection of followup information at selected sites where high rates of enrollment were achieved. Expanding these studies to enroll more patients and provide preventive services for longer periods of time would also provide additional information on the true effects of these services on the health of elderly people.

Conclusions

OTA's studies of selected preventive services highlight the difficult choices that Congress faces in shaping a Medicare strategy for preventive services. The decision of which preventive services should be Medicare benefits involves risks either way. On the one hand, including certain services in the Medicare law could increase Medicare and general health care expenditures without appreciably reducing beneficiaries' mortality, morbidity, or disability. On the other hand, if preventive services continue to be excluded from Medicare, real opportunities for better health and savings in health care costs could be lost for years to come. The services under consideration by the Committee today offer substantial health benefits at a ratio of cost to effectiveness that is roughly in line with preventive services already covered by Medicare.

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Table 1--Recommended Schedule for Active Immunization of Normal Infants and Children

Recommended age	Vaccine(s)
2 months	DPT #1[a] OPV #1[b] HbCV #1[d]
4 months	DPT #2 OPV #2 HbCV #2
6 months	DPT #3 HbCV #3
12 months	HbCV #3
15 months	MMR[c] DPT #4 OPV #3 HbCV #1 or #4
4-6 years	DPT #5 OPV #4
14-16 years	Td[e]

[a]DTP = Diphtheria and Tetanus Toxoids and Pertussis Vaccine.
[b]OPV = Poliovirus Vaccine Live Oral.
[c]MMR = Measles, Mumps, and Rubella Virus Vaccine, Live.
[d]HbCV = Vaccine composed of Haemophilus influenzae b polysaccharide antigen conjugated to a protein carrier. Two HbCV vaccines are licensed for infant use. A third is licensed for use in children 15 months of age and older. The recommended immunization schedule varies for each vaccine. See sources for specific information on HbCV vaccine schedules.
[e]Td = Tetanus and Diphtheria Toxoids.

SOURCE: Immunization Practices Advisory Committee, "General Recommendation on Immunization," Morbidity and Mortality Weekly Report, 38(13): 205-214,219-227, April 7, 1989; Immunization Practices Advisory Committee, "Haemophilus b Conjugate Vaccines for Prevention of Haemophilus infuenzae Type b Disease Among Infants and Children Two Months of Age and Older," Morbidity and Mortality Weekly Report, 40(RR-1): 1-7, January 11, 1991.

Table 2--Discounted Lifetime Costs of Screening, Followup, and Surveillance of Elderly People for CRC and Polyps Beginning at 65 Years of Age With 60 cm FSIG (discount rate = 5%, 1988 dollars)

Screening regimen[a]	Percent of population in surveillance base case (range)	Total cost for 1989 population of 65-year-olds base case (range)	Cost per person base case (range)
1	38% (23% - 55%)	$1.96 billion ($1.56 billion - $2.85 billion)	$940 ($751 - $1,369)
2	38% (23% - 55%)	$1.78 billion ($1.365 billion - $2.71 billion)	$856 ($651 - $1,299)
3	37% (25% - 55%)	$1.56 billion ($1.08 billion - $2.53 billion)	$750 ($520 - $1,213)
4	26% (14% - 45%)	$775 million ($514 million - $1.60 billion)	$372 ($247 - $767)

ABBREVIATIONS: FSIG = flexible fiberoptic sigmoidoscopy; FOBT = fecal occult blood test.

[a]Regimen 1: consists of screening with FOBT annually and with FSIG every 3 years until a person reaches the age of 85. Patients with polyps found and removed undergo periodic surveillance with colonoscopy every 4 years.

Regimen 2: consists of screening with FOBT annually and with FSIG every 5 years until a person reaches age 85. Patients with polyps found and removed undergo periodic surveillance with colonoscopy every 4 years.

Regimen 3: Annual FOBT; sigmoidoscopy once upon entry to Medicare.

Regimen 4: Annual FOBT; no sigmoidoscopy.

SOURCE: Office of Technology Assessment, 1990.

Table 3--Cost-Effectiveness of Colorectal Cancer Screening in the 1989 U.S. 65-Year-Old Population Under Assumptions Unfavorable to Screening[a,†]

Screening schedule	Costs				Effects					Cost Effectiveness
	Costs of screening, follow-up and surveillance[†,§]	Extra costs of treating lifetime latent cancers[†,‖]	Savings in treatment costs[†,§]	Net additional costs of screening[†]	Number of cancers prevented	Years of life gained from reduction in cancer mortality[†]	Years of life lost from operative mortality[†]	Years of life lost from complications of colonoscopy[†]	Net gain in years of life[†]	Cost per year of life gained[†,‖]
1: Annual FOBT/ FSIG every 3 yrs	$2.849	$0.404	$0.623	$2.630	33,549	83,393	13,660	8,610	61,323	$42,892
2: Annual FOBT/ FSIG every 5 yrs	$2.705	$0.404	$0.604	$2.504	32,579	81,016	13,567	8,528	58,921	$43,509
3: Annual FOBT/ FSIG on entry to Medicare	$2.526	$0.397	$0.524	$2.399	26,484	72,455	13,316	8,425	50,714	$47,308
4: Annual FOBT	$1.597	$0.387	$0.450	$1.534	22,756	61,821	12,723	5,340	43,758	$35,854

[a] For assumptions, see Table 2.

[‖] Costs shown in table are rounded to the nearest million dollars. Underlying calculations carried out on exact numbers.

[†] Years of life and costs are discounted to present value at a rate of 5 percent per year.

[§] This category includes costs of treating complications of colonoscopy.

[‖] Compared to no screening.

[¶] This category includes costs of treating complications of surgery.

Chairman STARK. Thank you.

Doctor, you heard the previous witness and the discussion of reimbursement and access. What can you tell us about the availability of these services? Is there enough capacity? In your opinion, would higher fees encourage more facilities and more people to use it?

What could we do to encourage more utilization among Medicare beneficiaries?

Dr. HERDMAN. Well——

Chairman STARK. Or do we need more capacity?

Dr. HERDMAN. Clearly, there is adequate capacity in the country. I think the National Cancer Institute has looked at that issue and that is their finding.

Chairman STARK. What was the finding?

Dr. HERDMAN. There is unused capacity for mammography.

Chairman STARK. Can I generalize? Can I say in most rural areas, there is capacity? In most inner cities?

Dr. HERDMAN. I would be a little reluctant to talk specifically about distributional availability of this technology because I really don't know about that. We could get back to you on that one, if you like. We will get back to you.

Chairman STARK. You would say categorically in terms of in the aggregate, there is no shortage of staffed people able to perform and with the equipment to perform to handle the population?

Dr. HERDMAN. Correct. OTA did a survey of mammography units, institutional mammography screening centers, and the like, at your request, and looked at the $50 price, at that time the $50 price in preparation for the catastrophic coverage act, we certainly don't have any position on this. As you know, we take no position.

I don't know, in fact, what the right price is today. At the time for mammography, we said that when we surveyed units, it was our view after surveying about 50 places around the country, that $50 would do it, that there would be adequate capacity at that price. Something which did not come up in the previous conversation is that screening mammography is one thing. Diagnostic mammography is another.

The cost of mammography is clearly the sum of the fixed cost—equipment, facility and so on—and the variable costs—how long it takes, staff time, film, and so on. We have not studied this either, but just for your information one could hypothesize that.

The fixed costs are covered by the $100, or whatever it is, fee that the diagnostic mammography is bringing to that facility. Screening mammography might be able to be done on a less expensive basis. In any event——

Chairman STARK. This is a marginal utilization?

Dr. HERDMAN. Correct. I don't know that. I am just suggesting that this is something worth looking into by your subcommittee.

You asked if higher fees would bring out more use. Would they stimulate providers to provide more mammography capacity?

Common sense tells me that they would if they were high enough. The question is are more units necessary? As I say, again, we felt the price to be paid for screening should reflect efficient production of services—and I would add when the Blue Cross and Blue Shield recommendations were made to their plans, they rec-

ommended that the mammography benefit be encouraged when tests are conducted with suitable quality management as evidenced by accreditation from relevant organizations and licensure from State agencies. When I discussed this with an official from the Chicago office of Blue Cross-Blue Shield—of course, they can't tell people what to pay because of antitrust problems—they are also suggesting that this meant that the plans orient in the direction of efficient producers rather than paying sort of a market rate.

I hope that has been helpful to you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I guess we will start finding out next year whether it works or it doesn't work. In regards to your statement, on the going demonstration projects regarding preventive health services, the six ongoing projects, you say we are not going to get a whole heck of a lot of information from those. Why?

Dr. HERDMAN. I think that is an accurate statement.

When we reviewed it, we made that statement in this document. I want to say our information is now a year, 1½ years old. If you will bear with me in terms of that caveat, the six projects got started late. At this time, they are due to go out for business, and it would not be a long enough period of time to collect the clinical patient outcome information as to what happens.

Mr. DONNELLY [presiding]. How long is that period of time?

Dr. HERDMAN. A couple of years. How much is needed?

Mr. DONNELLY. Yes.

Dr. HERDMAN. At least 5 years. That was not going to be the case. It is my understanding from reading your bill, Mr. Donnelly, that——

Mr. DONNELLY. The chairman's bill.

Dr. HERDMAN. The chairman's bill. The big chairman's bill. The bill suggests different demonstration projects than the ones that are currently ongoing and scheduled for termination. We were looking at glaucoma and osteoporosis and so on.

Mr. DONNELLY. Those are demonstration projects.

Dr. HERDMAN. As you know, we studied and reported to this committee on glaucoma screening. We are currently reviewing osteoporosis screening for some other committees. I think you need a considerable period of time to come to definite conclusions.

Mr. DONNELLY. That is my concern. Once we start getting into the realm of what preventive services are provided, we will add them on an ad hoc basis, like we do a lot of things around here. I have a real personal interest in osteoporosis screening.

I would fight like a son of a gun to have that covered. In reality, I think what Dr. Roper was suggesting is that we set up a mechanism within HCFA that would—and I would like to know if you concur—that would run these demonstration programs over a period of time, collect all the clinical data necessary and then make a recommendation on what and what not would be covered and what the cost ratio benefits would be.

Would that be, in your opinion, the best way to approach this?

Dr. HERDMAN. I would support that.

Mr. DONNELLY. These we are adding on an ad hoc basis.

Dr. HERDMAN. Clearly, I think OTA would feel that more information is needed about osteoporosis. We have spent the last year looking at it carefully.

It is a very, very complex subject. It sounds simple. As you probably know, it is not by any means. Screening is controversial. In fact, it is not recommended by any of the people that we have cited here today. The time horizons in osteoporosis are long ones for the perimenopausal woman going out many years. Bone density is obviously diminished. What certainly, it seems to me, is needed——

Mr. DONNELLY. Once you get to that point, there isn't a heck of a lot you can do?

Dr. HERDMAN. Once the bone is gone, you cannot get it back. You can't absolutely prevent it, but you can do a lot to prevent it, providing you are willing to go with the hormone treatments. But it will certainly——

Mr. DONNELLY. Usually that is prior to your eligibility to be a medicare beneficiary.

Dr. HERDMAN. It is clearly prior to Medicare eligibility. You can argue 65 is——

Mr. DONNELLY. Too late.

Dr. HERDMAN. Correct. We think it needs to be looked at over a considerable period of time very carefully and fund it adequately so you know it is going to happen. You know it is predictable and you can count on the study carrying through and being evaluated properly at the end.

I don't think it is an inexpensive business. I think it is worthwhile, but it is not cheap.

Mr. DONNELLY. You would recommend that when we proceed to expand these coverages that we do it on the basis of long-term demonstration projects, and analysis and data; that we not do it on sort of an ad hoc basis. The point I am getting to is this committee is going to be under enormous amount of pressure from every constituency group that has an interest in preventing one disease or another to add some sort of preventive diagnostic coverage in the program.

What I am concerned about is that we will start adding these sorts of preventive coverages based less on what best empirical data we can have versus what political pressure is put on the committee.

Dr. HERDMAN. OTA doesn't tell the committee what to do. If I were doing it, if you will extend that privilege to me for a second, then clearly I think that the committee is off to an excellent start. The benefits that you are talking about today are benefits which, in fact, obviously we have looked at very carefully.

We have reported them as benefits to you. They are supported not just by OTA, but by other people. They are based on trials and information, admittedly not perfect, but life is never perfect.

But there is substantial information. We could come to a cost effective figure on colorectal, breast, and cervical cancer, on influenza and so on. We could analyze, get enough data to analyze those things. We could tell you. You could say yea or nay at that point based on solid information.

You asked earlier, one of the members of the subcommittee asked earlier whether there are other benefits which Dr. Roper felt

could be added. I was thinking to myself he didn't answer that, and I couldn't answer it either. The fact of the matter is that I don't have a benefit that I would suggest that you add at this point. We are studying and we would be happy to continue to study these benefits. But I don't have the data in hand, and I don't think the data are in hand to buttress an additional benefit like, I think, this committee, this subcommittee wants to buttress it.

Mr. DONNELLY. Your recommendation is at this point in time to go no further beyond what is——

Dr. HERDMAN. As you know, OTA doesn't recommend, but I think it is problematic to go any further.

Mr. DONNELLY. Thank you very much. I yield my time.

Chairman STARK. Doctor, maybe you could help me on one more issue here. You have indicated that there is sufficient capacity in the country. I am sure that just incidentally you have come across some of the committee's work on physician referral. Basically there is another practice where you let one doctor bill for the work while another doctor reviews it and marks it up so it is kind of the reverse of referrals. You can do a little work in your office and then get an expert to review the film or the test and then bill the patient and mark it up, and we end up paying a little more for it. One of the schemes that purports to help us make mammography more available would be to rent this service through primary care physicians and/or put equipment in their office. Also, there are, I suspect, sellers of equipment who might like to encourage more primary care physicians to have that equipment along with all the other things a family practitioner might have, which arguably would be a lower volume service. The physician can only see a certain number of people a day, whereas a screening clinic can probably run hundreds through.

Can you comment on the advisability of encouraging more primary care physicians to do an occasional mammogram as opposed to encouraging more large volume centers?

Is there a clear benefit or cost difference in those types of procedures?

Dr. HERDMAN. Yes. Clearly, the volume provider, I think 100 is probably a little high, Mr. Chairman, but clearly—because, you know, you do probably 4 or 5 of these an hour. But for the volume provider—I mean, with one machine. But the volume provider clearly is more efficient and provides you with an experiential base, and if some studies are to be believed, experience improves quality.

OTA did have a report that indicated that sometimes that is a reasonable statement. Certainly it is cheaper. I think Blue Cross/Blue Shield said it well when they said they would like to see these in accredited facilities.

They were not talking about a private physician's back room with a machine where a couple of these things are done; somebody whose primary interest is not this, what I think what you just described.

Chairman STARK. I should get some information. Perhaps OTA could look at this. But what I understand one group that refers to them as Spectnoscan does, is they put a machine and technician in the doctor's office, but the doctor doesn't own the machine or the

technician. The doctor and technician provide the test. Then there is a radiologist somewhere else working for the company.

The net result is the doctor bills the patient for the mammogram. But the technology and the machine and the supervision, so to speak, is offshore in another office. Is that the kind of procedure, without any questions to quality of the radiologist involved. It seems that is a more convoluted a way and uses a lot more machines than to have a center which would be efficient and arguably provide a better quality.

Dr. HERDMAN. It is hard for me to comment. Is there a bill for the doctor?

Chairman STARK. If I am the GP and I do the mammogram through this system, I bill the patient and pay the radiologist. We had a good round on this a couple of years ago saying a doctor can't bill for another doctor. In other words, if I am an internist, I can't send you to the radiology and have the radiologist bill me, tack 10 percent on top and refer the bill on, which is strictly a cost-saving device. This is kind of that same kind of an operation.

I have a hunch it is a referral service situation, but it does involve additional equipment. I suspect that it is kind of a half a loaf. The doctor is not doing the work or supervising his or her own technician. The radiologist has a branch office in the GP's office. I guess that is a better way to define what they do.

Dr. HERDMAN. I guess the—we have not studied it. I would say what you are describing is a wrinkle on what I consider a reasonably legitimate practice.

For example, my wife is an occupational health nurse. In front of her business pulls up a van which does mammography for $50 a shot, which is a pretty good buy. You don't have to get a prescription. You can just go in. You have to give the name of your physician. They send the results to your physician and to you, the woman that is getting the test. That is all very nice. This is another way of going where the patients are, that is the doctor's office, but you are paying the doctor for that access. That is what it is. The question is whether that is legitimate.

Chairman STARK. I want to thank you very much. We will look forward to your continued advice as to how we can efficiently and effectively expand benefits under Medicare. As always, we appreciate your counsel.

I am going to ask that the remaining four witnesses come together to the witness table if they would. That would be Dr. Jacob Brody, who is the dean of the School of Public Health at the University of Illinois in Chicago, representing the Association of Schools of Public Health; Dr. Steinwachs, director of Health Services Research and Development Center at Johns Hopkins University in Baltimore; Dr. Skyler, the president-elect of the American Diabetes Association; and Anne Jackson, minority affairs spokesperson for the AARP. We will ask the four witnesses in the order they were called to present a summation or expansion of their prepared testimony to the committee.

Dr. Brody.

STATEMENT OF JACOB A. BRODY, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ILLINOIS, CHICAGO, ILL., REPRESENTING ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; ALSO ON BEHALF OF GILBERT S. OMENN, M.D., Ph.D., PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Dr. BRODY. Thank you. I am pleased to have the opportunity to testify in favor of H.R. 2565, the Medicare Preventive Benefits Act of 1991.

You have already identified me as Jacob Brody, physician and dean of the School of Public Health at the University of Illinois at Chicago. Unfortunately, not a close acquaintance of the big chairman. I am speaking on behalf of the Association of Schools of Public Health. I previously served as the associate director of the National Institute on Aging at the National Institutes of Health.

H.R. 2565 is urgently needed legislation which will benefit older Americans as well as offering a real potential for reduced costs to the Federal Government. The bill includes screening for various cancers. In addition, coverage of certain immunizations which are a proven merit and should be embarked upon without delay.

Provisions for demonstration projects covering other preventive services and the establishment of an Office of Technology Assessment process for review of Medicare coverage of other preventive services, both present opportunities for humane progress at minimal cost.

The Association of Schools of Public Health recommends the establishment of the Federal Trust Fund for Prevention, Education and Practice, which will be funded by earmarking 0.1 percent of Medicare funds yearly. This would be approximately $150 million a year and is, by definition, revenue neutral, but is likely to result in increased cost savings by preventing or mediating diseases that are so costly to Medicare. I have attached a summary of the proposal to my testimony. We also advocate the "Welcome to Medicare" provision in H.R. 2565, a one-time comprehensive assessment, as a key tool for prevention and early intervention.

At present, almost 80 percent of all deaths in the United States occur at age 65 or over. Dying is clearly and increasingly within the province of Medicare. This 20th and 21st century phenomenon must shift our thinking to the necessity to preserve active life expectancy, the years lived in good health with no functional limitations. We will all be dying old. Among the most prominent factors which compromise active life expectancy and detract from health and well-being in aging are arthritis, diminished hearing and visual acuity, dementia, hip fracture, incontinence, and depression.

These conditions, either singly or jointly, contribute to loss of active life expectancy, the increased risk of complex, chronic conditions and, ultimately, institutionalization. They surely comprise the most expensive and disruptive conditions we face. This will become increasingly the case as we approach the year 2000 at which time probably no more than 18 percent of all deaths will occur before age 65.

The main approach to prevention in the population 65 and over is through postponement of these conditions which are increasingly prevalent, costly and compromising for the older American. An ex-

ample of postponement as prevention is hip fracture. Half of the deaths after age 65 occur after age 81.

Chairman STARK. What do you know about celibacy and abstinence? Is that too much for hip fracture?

Dr. BRODY. There are data about nuns and hip fracture. It is primarily a female disease.

Chairman STARK. Celibacy is?

Dr. BRODY. Well——

Chairman STARK. I hope.

Dr. BRODY. Yes.

The average age of those experiencing hip fractures is 78. Hip fracture is related to osteoporosis and bone metabolism. We know that diet, exercise, hormonal and vitamin therapy, and environmental factors such as preventing falls will all lower the rate of hip fracture. Most important, however, would be to determine how to slow the age-dependent process of osteoporosis which actually begins in the late teens. This is possibly a true example where education, diet, preventive medication and, perhaps, studies which instruct us on how to slow the process of osteoporosis, all contribute. The rate of hip fracture doubles every 6 years from age 40 on.

Thus, it would merely take a 6-year delay in the osteoporotic process to reduce hip fractures by 50 percent. In so doing, we move the average age of hip fracture from 78 to 84, or beyond the most likely ages of dying.

By postponing hip fractures beyond death, we have truly prevented their occurrence. My fellow deans and I urge you to enact the Medicare Preventive Benefits Act and the Federal Trust Fund for Prevention, Education and Practice.

Through a combined attack on the part of our elected leaders, health professionals and an enlightened citizenry, we could contemplate postponing the onset of deafness, blindness, joint and mobility diseases and, above all, Alzheimer's disease and related disorders which are the conditions that drain our Medicare system, and lead to costly institutionalization and give aging a bad name.

With your permission, I request that the written testimony of Dr. Gilbert S. Omenn, president of ASPH and dean of the School of Public Health and Community Medicine at the University of Washington be incorporated into the record of this important hearing and that I be allowed to summarize his remarks at this time.

As you recall, Mr. Chairman, Dr. Omenn testified in April on the need for the "Welcome to Medicare" program that we believe is the cornerstone of H.R. 2565. Dr. Omenn was originally scheduled to testify before this committee on June 17. Since the date of the hearing was changed, he is unable to be here today.

Briefly, Dr. Omenn's testimony applauds the bipartisan leadership reflected in H.R. 2565 to expand provision of appropriate preventive services benefits for Medicare beneficiaries. He provides some specific comments on the proposed benefits, including a caution that mammography every other year is probably sufficient for women age 50 and above—unless in high-risk categories—so long as they receive a clinical breast exam annually and do get the mammogram every other year.

He and I particularly support the permanent extension of the Medicare prevention demonstrations as sites for research and eval-

uation of services and of methods for delivering those services. He stresses the risk that "business-as-usual fee-for-service" preventive care may not be as cost effective as population-based preventive services.

Our model for the "Welcome to Medicare Visit" would be based on a demonstrated scheme for individual health risk assessment and then well-directed followup services, involving a team of providers, not just a routine doctor's office visit.

Thank you for the opportunity to testify, Mr. Chairman. Your committee is to be commended for holding this hearing on Medicare coverage of preventive services.

[The statement of Dr. Omenn follows:]

TESTIMONY BEFORE HOUSE WAYS AND MEANS COMMITTEE 17 June, 1991,
on H.R. 2565, the MEDICARE PREVENTIVE BENEFITS ACT of 1991

by Gilbert S. Omenn, M.D.,Ph.D., University of Washington
Professor of Medicine and of Environmental Health
Dean, School of Public Health & Community Medicine
Director, UW Center for Health Promotion in Older Adults
President, Association of Schools of Public Health

Mr. Chairman and Members of the Committee, I am Gilbert Omenn, a physician from Seattle, Dean of the School of Public Health & Community Medicine at the University of Washington, and President of the Association of Schools of Public Health (ASPH).

The Association of Schools of Public Health is the national organization representing the deans, faculty, and students of the 24 schools of public health throughout the country. The Schools of Public Health constitute the primary education systems for training of the women and men needed to operate our Nation's public health, disease prevention, and health promotion programs. ASPH's principal purposes are to promote and improve the education and training of professional public health personnel and to stimulate biomedical, behavioral, environmental, epidemiologic, and policy research aimed at better health and more effective and cost-effective health care for all Americans.

Mr. Chairman, I applaud the introduction of H.R. 2565, the leadership you and Mr. Stark and Mr. Chandler have provided, and the broad bipartisan support in the Committee for this groundbreaking legislation. I support the provision of appropriate Preventive Services Benefits for Medicare beneficiaries.

Background

In retrospect, the decision in 1965 to exclude preventive services from Medicare was pennywise and pound-foolish. At age 65, a dividing line which itself is an anachronism from the time of Bismarck in 1885 in Germany, men have an average life expectancy of 14 years and women an average life expectancy of 19 years. That is plenty of time to enjoy any benefits of health promotion and disease prevention! The alternative is an excess of chronic illness, with its attendant financial and social costs (see exhibit 1).

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Worse than simply an omitted benefit, the original Medicare decision set a precedent for neglect of prevention in older Americans. For example, in the huge NIH prevention demonstrations like the Multiple Risk Factor Intervention Trial (MRFIT) participants were restricted to ages 35 to 57. Similarly in the much-cited cholesterol-lowering trial in the Lipid Research Centers, the Coronary Primary Prevention Trial, only men ages 35 to 59 were eligible. The Surgeon General's 1979 report Healthy People and the first Health Objectives for the Nation report in 1980 included two appropriate goals for older Americans: improving functional independence and increasing influenza immunization to prevent premature deaths from pneumonia (not just prolonging life). However, the Mid-Course Review on the 1990 Objectives (through 1985) gave little attention to Older Adults.

In the late 1980s this pattern has been overcome. The Office of Disease Prevention and Health Promotion has been very active, together with the American Association of Retired Persons (AARP) and other national organizations, in promoting HP/DP among older people. Its U.S. Preventive Services Task Force carefully evaluated numerous screening tests, counseling services, and immunization practices and has had a major dissemination effort to physicians. The Year 2000 Health Objectives for the Nation gave prominent attention to quality of life and specific objectives for older Americans. The Centers for Disease Control funded one of its first three Prevention Centers, at our University of Washington School of Public Health, entirely devoted to "Keeping Older People Healthy and Independent". The National Institute on Aging has supported a growing array of research on prevention of falls and other problems important in older people, and the National Cancer Institute and the National Institute on Aging have cooperated on various cancer prevention initiatives (see exhibits 2 & 3).

Most importantly, this Committee mandated the Health Care Financing Administration to support several Demonstration Projects on Financing of Preventive Services for Medicare-eligible elderly. Dr. Donald Steinwachs of Johns Hopkins School of Hygiene and Public Health will address these demonstrations with a national perspective; exhibit 4 summarizes the demonstration at Group Health Cooperative in Seattle headed by Dr. Donald Patrick. Finally, this Committee has requested assessments by the OTA of the medical effectiveness and cost-effectiveness of a series of procedures or tests, which have been carried under the leadership of Dr. Judith Wagner of OTA and have been described already this afternoon.

Medicare does now cover pneumococcal and hepatitis B vaccination, paper smears, and mammography, as noted in the Chairman's opening message.

As we discussed here in the opening hearing of this series on 16 April, 1991, there is a crying need to look at the health needs of Americans across the whole population and not just among the individuals who present themselves one-by-one to doctors and

hospitals for emergency or acute care. Part of that effort of assurance of health care services must be preventive.

Comments on H.R. 2565, Medicare Preventive Benefits Act of 1991

The proposed legislation has many attractive features:

1. The benefits proposed for inclusion--colorectal cancer screening, influenza and tetanus immunizations, and mammography--address cancer, influenza pneumonia, and breast cancer. Each has been subjected to detailed review by the Office of Technology Assessment.

Even for these seemingly straightforward benefits, business-as-usual is not sufficient. Care must be exercised in preparing patients to collect stool for occult blood tests, in doing the lab tests, and in doing the endoscopy procedures for the colorectal screening and follow-up. High-risk groups among the elderly should be identified, just as at ages lower than 65, to enhance the participation of patients and physicians in flu immunization. And high-quality, high-volume mammography stations should be facilitated for mammographic screening and interpretation with economies of scale.

I should note that there is considerable controversy about whether screening mammography should be done annually, or biennially. The Preventive Services Task Force decided that biannual screening is sufficient. I understand from my colleagues at the Fred Hutchinson Cancer Research Center in Seattle that the National Cancer Institute may hold another consensus conference on this matter and that the main reason that the American Cancer Society holds to annual screening is to assure that women do get regular mammography, instead of letting it slip more than two years. In fact, many women have yet to undergo their first mammography examination.

I do support the Committee's intention to offer women 65 and over the same service as is provided for women 50-64; however, I think the Committee might be well-advised to obtain further opinions from OTA and ACS and other sources about whether a highly promoted biannual exam would be just as efficacious as the current scheme of providing funding for some women to get the exam annually.

2. The permanent extension of the Medicare Prevention Demonstrations as sites for research and evaluation of preventive services AND methods for delivering those services reflects a longterm commitment to prevention and to a sound scientific basis for coverage decisions.

The Committee recognizes the crucial need for better knowledge about the efficacy and cost-effectiveness of various specific preventive measures and of strategies to get the services to a maximal number of people most needing them. There is a general problem in medical care and in prevention that too often the people

who need the services most are least likely to seek them or respond to business-as-usual service delivery.

The Schools of Public Health have mobilized collectively and individually to undertake these kinds of research and evaluation studies. The HCFA Demonstrations are based at schools of public health, working with community providers, and much of the research upon which OTA relies for its reviews of the literature has been performed by faculty at schools of public health.

3. The specific mention of "methods of delivering such services" raises the overriding organizational and cost-containment question of how best to reach large numbers of people for screening and do so at affordable cost. This issue deserves the attention your bill language can stimulate.

There is a considerable risk that the business-as-usual fee-for-service model, applied to population-based screening objectives, will be excessively costly per person served and too irregular in reaching target populations. We must ask why the "uptake" on flu immunization and on mammography has been so slow. We must learn from the huge literature now on variation in medical practice even within small towns or group practices. We should try to build on the movement toward managed care to test and implement cost-effective multi-faceted health promotion/disease prevention services, rather than buying each service one-at-a-time.

The concepts of population-based preventive services are not familiar to many physicians, despite the efforts of the U.S. Preventive Services Task Force and many professional organizations. Evidence that certain tests or interventions may not be efficacious or cost-effective may fall on deaf ears once a practice is initiated and heavily promoted.

Cholesterol screening and use of cholesterol-lowering drugs for older people, especially with only moderately elevated cholesterol, is an important example of over-treatment and unjustified cost. It is appropriate that you mandate review of cholesterol screening and treatment, but professional organizations and payers must be willing to discourage certain practices until positive evidence of value is obtained, not just allow such practices to become embedded. The Preventive Services Task Force and the American College of Physicians have issued such red flags on cholesterol screening.

Another example of over-diagnosis and over-treatment in older people is mild elevation of diastolic blood pressure. There are problems in measurement of blood pressure--not as simple a measurement as you might think--and problems arising from measuring the blood pressure while the patient is all keyed up. And then there are complications of potent medicines that exceed the likely benefits.

Critical, constructive assessments of preventive services are

appearing, both in the policy literature from OTA and in journals for clinicians, in articles from the U.S. Preventive Services Task Force and other organizations and in volumes like a special issue of Clinics in Geriatric Medicine which my colleagues and I are editing (list of topics appended as exhibit 5).

My colleagues and I in the Association of Schools of Public Health applaud this provision, which seems to build upon our recommendation of a "Welcome to Medicare" health promotion/disease prevention visit. This visit could involve an efficient team, not just an individual physician, and should not be seen as a simple addition to a standard office visit. Most physicians are reluctant or unprepared to counsel their patients about nutrition, smoking cessation, physical activity, let alone living wills, sexual function, and social networking.

The "welcome to Medicare visit" must be based upon a demonstrated algorithm of individual health risk assessment and then well-directed follow-up services. The HCFA Demonstrations are providing good models for this kind of multi-faceted service; data will be suitable for review by OTA and Congress by this time next year, I trust.

Additional Points to Consider

1. Preventive Services for Medicare-Eligible Disabled Persons
One novel provision of H.R. 2565 is the inclusion of well-baby and well-child care and immunizations for ESRD children under age 6. These recommendations are sound and inexpensive.

Another step that should be considered at this time is to fund a feasibility study at one or more of the HCFA demonstration sites to ascertain the kinds of preventive services that should be offered and evaluated for Medicare-eligible disabled persons. It is timely to follow-up on the Americans with Disability Act of 1990 and efficient to utilize the capable faculties at one or more of the HCFA sites already in operation.

2. Need for More Research Funding by HCFA
It is shocking that an agency with program expenditures exceeding $100 billion per year has a research funding capability of only $30 million or so. I hope that this Committee will review the research needs of the agency and consider ways in which the combination of appropriated funds and trust funds might be utilized to support necessary research, including, of course, research and demonstration on the themes of H.R. 2565.

3. Need for Preventive Services Research Support by PHS Agencies
The Centers for Disease Control, the NIH institutes, and the Agency for Health Care Policy and Research all should be asked about their programs to fund research on health promotion and disease prevention for older Americans.

Closing Comment

The Association of Schools of Public Health will be pleased to continue to work with the Committee and your excellent staff to develop further this initiative this year and in the years ahead. We appreciate your involving us in these Hearings and in the preparative work.

Exhibits

1. Omenn, "Prevention and the Elderly: Appropriate Policies", in Health Affairs, summer 1990, 9:80-93.

2. U.S. Preventive Services Task Force, "Recommendations for Older Adults".

3. Omenn, "The University of Washington Center for Health Promotion in Older Adults", in Perspectives in Prevention, 1988,

4. Patrick, "A Healthy Future, the HCFA Demonstration at Group Health Cooperative and University of Washington".

5. Table of Contents for forthcoming issue of Clinics in Geriatric Medicine on Prevention in Older Patients.

PREVENTION AND THE ELDERLY: APPROPRIATE POLICIES

by Gilbert S. Omenn

Prologue: *National demographic statistics show that the elderly population of this country has increased rapidly and will continue to grow into the twenty-first century as the postwar baby-boom generation ages. Experts have debated whether health promotion activities can be effective among older people, since one of the goals of health promotion is to prevent premature death and illness. In response to this debate, the University of Washington's Center for Health Promotion in Older Adults, the first of its kind in this nation, studied an older population of 25,000 patients being treated for coronary artery disease. Its findings dispel the notion that health promotion "is not worth it" for older people: older men and women benefited just as much from smoking cessation programs as did their middle-aged counterparts. In this article, Gilbert Omenn concludes, "As people live longer, there are more years for older people to benefit from health promotion/disease prevention activities." He advocates the concept of "successful aging," arguing that older people no longer have to be "willing to accept declines as the inevitable consequences of age." Omenn received his medical degree from Harvard Medical School and a doctorate in genetics from the University of Washington in Seattle. He is professor of medicine and of environmental health, director of the Center for Health Promotion in Older Adults, and dean of the School of Public Health and Community Medicine at the University of Washington in Seattle. He served as deputy science advisor and later as associate director of the Office of Management and Budget in the Carter administration. He is a member of the U.S. Congress Office of Technology Assessment Panel on Preventive Services under Medicare, the Institute of Medicine (IOM) Board on Health Promotion/Disease Prevention, and the Charles A. Dana Foundation Health Advisory Board.*

People 2000: National Health Promotion and Disease Prevention Objectives. The American Association of Retired Persons (AARP) and others have been increasingly active in health promotion as well.

When Is It Too Late To Begin Health Promotion Activities?

Ironically, one of the indirect results of a comprehensive life-cycle view of the origins of chronic diseases and injury-prone lifestyles is the conclusion that prevention must begin early and that once a person is sixty or seventy years old, it may be too late. For example, in the list of activities specified in *Healthy People*, smoking cessation is conspicuously missing, despite the recognition that smoking is a dominant risk factor in coronary artery disease, many cancers, and chronic lung disease—the big killers and cripplers of older people. Similarly, most medical textbooks and many physicians, even now, consider smoking cessation to have limited value among older people. The logic is that any longtime smoker who is still alive at age sixty-five or so may somehow be "resistant" and is unlikely to benefit from breaking the habit.

A study from the University of Washington's first-of-its-kind Center for Health Promotion in Older Adults demonstrated that, among older men and women (drawn from the Coronary Artery Surgery Study of 25,000 patients evaluated for symptoms of coronary artery disease), such presumptions are wrong. Survival for six years of follow-up was just as poor for smokers, compared with former smokers and never-smokers, among participants age sixty-five and older as among those ages thirty-five to sixty-four. More importantly, comparisons of those who continued to smoke during the follow-up with those who quit in the year preceding enrollment in the study found 60 percent higher survival among the "quitters," with the same differential in all three age groups.[8] Thus, on an individual basis, the older men and women benefited just as much from smoking cessation as did their middle-aged counterparts, adjusted for various coronary risk factors. On an aggregate basis, the older age group benefited far more, since the incidence of heart attacks and deaths rises markedly with age.

Increased longevity. As people live longer, there are more years for older people to benefit from health promotion/disease prevention activities. At age sixty-five, on average, men can be expected to live almost another fifteen years and women, another nineteen years. Preventive efforts should be focused on modifiable risky health behavior and early diagnosis, matched to the leading problems by age and functional status. The notion of a generalized annual check-up is no longer favored at any age. In fact, we have demonstrated that age becomes a nonsignificant

variable when falls and several specific chronic conditions are accounted for in a detailed analysis of restricted activity days among older adults.[9]

The University of Washington Center for Health Promotion in Older Adults, supported by the federal Centers for Disease Control (CDC) Prevention Centers program, is dedicated to the notion that it is not too late to attempt major health promotion/disease prevention initiatives among older people.[10] As with younger age groups, the biggest challenge is to entice those who most need to participate—sedentary, smoking, older, low-income, socially isolated, sensory-impaired, multiply medicated, or depressed individuals. The center consists of (1) a methodology core, to develop and validate instruments for measurement of health status in older adults, beginning with overall status, physical activity, and depression; (2) case-control studies of the preventable factors that predispose individuals to falls and hip fractures; (3) a major demonstration at Group Health Cooperative of Puget Sound with 1,800 older adults randomized into two groups, one receiving usual care and the other receiving special preventive services that address physical activity, rationalization and reduction of medications, assessment and improvement of vision and hearing, moderation of excessive alcohol intake, and assessment of home safety (which few accept); (4) developmental projects, such as the smoking/quitting analysis above, linkage of pharmacy and health care utilization records at Group Health, validation of noninvasive bone density measurements, and investigations of factors associated with motor vehicle accidents; and (5) dissemination of methods and results, and interaction with community advisers.

Prevention Recommendations For Older Adults

There are three major sources of recommendations for older adults' prevention activities: the Lifetime Health-Monitoring Program by Lester Breslow and Anne Somers, the Canadian Task Force on the Periodic Health Examination, and the *Guide to Clinical Preventive Services* from the U.S. Preventive Services Task Force.[11] In addition, communitywide health protection and health education efforts complement the preventive services potentially provided by various health professionals.

Breslow and Somers introduced the concept of packages of selected services for various age groups, with age-group-related periodicity. For the elderly (ages sixty to seventy-four) and those in old age (age seventy-five and over), the goals are to prolong the period of optimal physical, mental, and social activity; minimize disability, discomfort, and inactivity from chronic conditions; prepare in advance for retirement; and be supportive in the face of terminal illness. They recommend professional

routine part of essentially every physical examination, and even blood pressure is omitted by many specialists. Increasingly, older adults are taking their own blood pressures in drug stores and shopping centers. Less than 15 percent reported an annual rectal exam, pneumococcal vaccination, or mammography (women), but 50–70 percent of women had Pap smears within one to four years, and 74 percent reported eye exams within two years. Between 1973 and 1982, National Health Interview Surveys found increases in the proportions of elderly who had ever had breast self-examinations, Pap smears, eye examinations, electrocardiograms, or glaucoma testing.

Several studies have examined the preventive services provided by various types of physicians.[13] Primary care physicians seem to recommend more preventive services than do specialists. In both categories, physicians seem to prefer tests not requiring their personal involvement or their time for counseling. Many physicians reported that they recommend more services than do the published guidelines, because various guidelines are too cautious or inconsistent.

However, despite extensive educational efforts directed at both physicians and patients by the ACS, use of mammography, as a key example, is still discouragingly low. The 1987 National Health Interview Survey found that only 20 percent of all women age fifty and over had had a mammogram in the previous year; a CDC Behavioral Risk Factor Surveillance System survey in thirty-three states in the same year found that, even among women in this age group who had seen a physician for routine preventive care, only 29 percent had had a mammogram. The reasons? Many women are not aware of the frequency of breast cancer and the proved efficacy of mammography in dramatically reducing breast cancer deaths. Physicians seem unduly skeptical. And, charges for mammography are a highly variable barrier, often more than $100. Few public health departments provide mammography for low-income clients, either.[14] Nevertheless, even these figures do represent some progress. In the RAND Health Insurance Experiment, only 2 percent of women ages forty-five to sixty-five had had a mammogram in the three-year period 1974–1977, and free care alone was an insufficient incentive to yield adequate levels of preventive services.[15]

Can Prevention Be Cost-Effective?

Preventive actions, in both the clinical and community arenas, seem to face far more scrutiny of their likely efficacy and costs than do diagnostic tests and treatments. Perhaps much of this public attitude reflects Americans' predisposition to face up to crises (medical, in this case) and to

reduction of current risks from unhealthy behavior, since preventive services are also underused in Britain, where there is, in principle, quite a good system for linking health maintenance with medical care.[16]

Total costs of population-based health promotion programs can become rather substantial if screening tests and counseling are provided to large numbers of people, with confirming diagnostic workups for those at "high risk," to prevent relatively few adverse events per year. The benefit-to-cost ratio drops further if high-risk individuals disproportionately are missed in the program (as is usual), if individuals fail to follow through with recommended behavior changes or medicines, or if the target population is heterogeneous for conditions screened and for responses to preventive services. Thus, Louise B. Russell, for example, criticized early detection and preventive treatment with drugs to control high blood pressure, and the resource costs and likely benefits of exercise programs.[17]

Assessing prevention programs. Generalized analyses of health promotion and disease prevention programs can be misleading. It is essential to specify the target populations by age, sex, racial and ethnic group, underlying incidence of predisposing preventable risk factors, portion of the risk attributable to each of those factors and their combinations, willingness to participate, and compliance with recommendations. It is also essential to distinguish what classically have been termed primary, secondary, and tertiary approaches to disease prevention. Primary prevention aims to avert the initiation of the disease process. Secondary prevention aims to detect early signs of disease before the person is clinically affected. Tertiary prevention aims to prevent serious and often costly complications of already-diagnosed disease.

Some of these considerations make the benefit/cost ratio of preventive services potentially more favorable in older men and women than in their middle-aged counterparts—if the interventions are successful. Primary prevention may seem less useful in older people if it must precede the onset of the disease process by many years. Nevertheless, the reduction in coronary mortality from smoking cessation noted earlier has a much larger aggregate benefit from essentially the same intervention costs, because the mortality rate is so much higher in older adults. Similarly, because older people have a higher incidence of serious illnesses and death from influenza and pneumococcal pneumonia, immunization, if effective, will be more cost-effective in older age groups. Also, the mortality and morbidity rates of most cancers rise sharply with age, so any secondary prevention program that works in older adults should generate

demonstrations are under intense pressure to produce results with minimally adequate sample sizes and brief periods of follow-up. As is so often the case, the responsible agency, interested congressional staff, and exter-

nal groups keen to obtain funding for preventive services are impatient for results and general implementation of a prevention program. The deliberate pace of new public program investments these days surely would justify more extensive demonstrations during this period and longer follow-up than is currently budgeted. Congress should mandate at least a five-year follow-up if cost-effectiveness is not apparent after three years.

Priority For Prevention

It is ridiculous to expect health promotion and disease prevention to accomplish grand-scale cost containment in the health care sector in the face of continuing escalation of expenditures for diagnosis, treatment, and long-term care. However, it is reasonable to expect well-selected health promotion and disease prevention initiatives to achieve improvements in health status, maintenance of functional independence, and *moderation of increases* in health care use and spending. We must reach agreement on measures of quality of life and social contribution, so benefits of cost-effectiveness from prevention programs can be compared with marginal benefits from continuing or additional specific treatments. Especially critical comparisons should be made with high (and often futile) expenditures in the last days or weeks of life and with expenditures for custodial care after severe mental and physical decline. Also, we need to design health maintenance and health promotion for spouses and other relatives with whom intense relationships may be formed during the decision-making process about terminal or long-term care for a primary patient.

As the U.S. labor market shrinks, we will need to reach out to retirees for additional periods of work. Then the capacity of older people to respond will take on greater economic value, as will effective health promotion/disease prevention programs. If physicians and families comprehend the concept of "successful aging"—maintaining bodily functions by avoiding specific causes of impairment—and the value of patient autonomy, we will be more aggressive about maintaining function and less willing to accept declines as the inevitable consequences of age.[20]

Health Promotion/Disease Prevention In Clinical Practice

The resistance of most physicians to counseling their patients about nutrition, smoking, physical activity, let alone living wills, sexual function, and social networking is well known.[21] Furthermore, most patients are reluctant to initiate such discussions with their physicians. Yet, I

believe that those physicians who do engage their patients in such health promotion topics elicit productive responses and much appreciation from their patients. Several steps are required to alter behavior of physicians and patients.

The roles of physicians and patients. Research, demonstration, and consensus-building exercises such as those of the Canadian and U.S. prevention task forces must continue to generate understandable and persuasive messages to professionals and consumers alike about which health promotion/disease prevention activities are efficacious and for which populations they should be provided. Patients must request or demand attention to pressing, usually unasked questions, either from their physicians or other health professionals or from peer groups.[11]

The role of the private sector. Society must begin to pay professionals for the time involved in addressing these important concerns. Perhaps the initiative must come from the private sector, especially from companies with enormous liabilities for health insurance for their present and future retirees—some of whom they may wish to tap for further work, including training of others, and all of whose health care costs they would like to moderate. Company purchasers of health programs may be able to negotiate packages of preventive services, both counseling and screening services, taking their cues from the U.S. Preventive Services Task Force and from the HCFA demonstrations. Many payers understandably fear fee-for-service unbundling and gouging; they might respond more favorably to negotiated packages and capitated, total care rates. Costs must be reviewed and constrained based on target populations, not on an individual services basis, with substantial economies of scale.

Government's role. Federal and state governments, worried about consequences to society of unnecessarily dependent older adults and seeking to make rational choices about the full array of services to include in ambulatory and long-term care programs, must step up to the table and pay their share. Low-income, Medicaid-eligible elderly, veterans served by the Department of Veterans Affairs (VA), and military and civilian retirees are important target populations for which government has direct responsibility.

It would be unwise to perpetuate the inflationary incentives embedded in the acute care sector by extending reimbursement step-by-step from pneumococcal vaccine to hepatitis B vaccine to mammograms to, say, the taking of blood pressure. Better by far would be payment for a systematic health assessment of older persons, drawing upon a package of potential services available, with some services requiring payment by the individual and counted against deductibles. One productive suggestion considered in the 100th Congress's debates on the Medicare Catastrophic

1987): 32-41.

4. U.S. Senate Special Committee on Aging, *Aging America: Trends and Projections*, 1987-1988 ed.; American Association of Retired Persons, *A Profile of Older Americans, 1988* (Washington, D.C.: AARP, 1988); L.M. Verbrugge, "Recent, Present, and Future Health of American Adults," *Annual Review of Public Health* (1989): 333-361; "The Aging Society," *Daedalus* (Winter 1986); and D.P. Rice and J.J. Feldman, "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly," *The Milbank Memorial Fund Quarterly* (Autumn 1983): 362-396.
5. Ibid.
6. U.S. Public Health Service, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, DHEW (PHS) Pub. no. 79-55071 (Washington, D.C.: U.S. Government Printing Office, 1979): 71-80, 154-155.
7. PHS, *Promoting Health/Preventing Disease: Objectives for the Nation* (Washington, D.C.: U.S. GPO, Fall 1980); PHS, *The 1990 Health Objectives for the Nation: A Midcourse Review* (Washington, D.C.: U.S. GPO, November 1986); PHS, *Surgeon General's Workshop: Health Promotion and Aging, Proceedings* (Washington, D.C.: Public Health Service, March 1988); and PHS, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (forthcoming, September 1990).
8. B. Hermanson et al., "Beneficial Six-Year Outcome of Smoking Cessation in Older Men and Women with Coronary Artery Disease: Results from the CASS Registry," *The New England Journal of Medicine* (24 November 1988): 1365-1369; and G.S. Omenn et al., "The Temporal Pattern of Reduction of Mortality Risk after Smoking Cessation in Men and Women with Symptoms of Heart Disease: A CASS Registry Report," *American Journal of Preventive Medicine* (forthcoming, 1990).
9. M.R. Kosorok et al., "Conditions Which Account for Restricted Activity Days among Older Adults," *Abstracts, Prevention '90* (Atlanta: Prevention '90, 21 April 1990).
10. G.S. Omenn, "University of Washington Center for Health Promotion in Older Adults," *Perspectives on Prevention* (Winter 1988): 50-55; G.S. Omenn, "Keeping Healthy Older People Healthy," *Washington Public Health* (Seattle: University of Washington Center for Health Promotion in Older Adults, January 1989): 47-48; and W.B. Carter et al., "Health Education: Special Issues for Older Adults," *Patient Education and Counseling* (Spring 1989): 117-131.
11. L. Breslow and A.R. Somers, "The Lifetime Health-Monitoring Program: A Practical Approach to Preventive Medicine," *The New England Journal of Medicine* (17 March 1977): 601-608; Canadian Task Force on the Periodic Health Examination, "The Periodic Health Examination, and Updates," *Canadian Medical Association Journal* (3 November 1979): 1193-1254; (15 May 1984): 1278-1285; (1 April 1986): 721-729; (1 April 1988): 617-626; U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services* (Washington, D.C.: DHHS, May 1989); and R.S. Lawrence and A.D. Mickalide, "Preventive Services in Clinical Practice: Designing the Periodic Health Examination," *Journal of the American Medical Association* (24 April 1987): 2205-2207.
12. U.S. Congress, Office of Technology Assessment, "The Use of Preventive Services by the Elderly" (Staff paper in OTA's Series on Preventive Health Services under Medicare) (Washington, D.C.: OTA, January 1989).
13. Ibid.
14. Public Health Foundation, "Few Women Receiving Screening Mammograms," *Public Health Macroview* (July/August 1989): 1-2; and N. Lurie et al., "Preventive Care: Do We Practice What We Preach?" *American Journal of Public Health* (July 1987): 801-804.
15. Ibid.
16. S.J. McPhee and S.A. Schroeder, "Promoting Preventive Care: Changing Reimbursement Is Not Enough," *American Journal of Public Health* (July 1987): 780-781.

17. L.B. Russell, *Is Prevention Better than Cure?* (Washington, D.C.: The Brookings Institution, 1986).
18. D.L. Patrick, W. Beery, and M. Durham, "Cost-Utility of Medicare Reimbursement for Preventive Services in an HMO," and D.L. Patrick et al., "A Healthy Future: Can Preventive Care Improve Your Health and Quality of Life?" (Unpublished reports, Department of Health Services, University of Washington, and Group Health Cooperative, Puget Sound).
19. PHS, *Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation* (Draft for public review and comment) (Washington, D.C.: U.S. GPO, September 1989). The term "years of healthy life" is introduced here to replace "quality-adjusted life years."
20. Somers, "Why Not Try Preventing Illness?;" Rowe and Kahn, "Human Aging;" Butler and Gleason, eds., *Productive Aging;* Katz et al., "Active Life Expectancy;" Hazzard, "Preventive Gerontology;" Fries, "Aging, Natural Death, and the Compression of Morbidity;" and Bruce and Larson, "Commentary on Paradigm of Compression of Morbidity."
21. R.J. Pels, D.H. Bor, and R.S. Lawrence, "Decision Making for Introducing Clinical Preventive Services," *Annual Review of Public Health* (1989): 363-383.
22. S. Greenfield, S. Kaplan, and J.E. Ware, Jr., "Expanding Patient Involvement in Care: Effects on Patient Outcomes," *Annals of Internal Medicine* (April 1985): 520-528; J. Rodin, "Aging and Health: Effects of the Sense of Control," *Science* (19 September 1986): 1271-1276; and Institute of Medicine, *America's Aging: The Social and Built Environment in an Older Society* (Washington, D.C.: National Academy Press, 1988).
23. The present annual funding for these activities is truly negligible—only $1.9 million nationally for the program of prevention centers and $1.75 million for the HCFA demonstrations.

Exhibit 2

TABLE 1. PREVENTIVE SERVICES TO BE CONSIDERED IN OLDER ADULTS*

SCREENING

History
- Dietary intake
- Physical activity
- Tobacco/alcohol/drug use
- Functional status at home
- Prior symptoms of transient ischemic attack

Physical Examination
- Height and weight
- Blood pressure
- Visual acuity
- Hearing and hearing aids
- Clinical breast examination†

High-Risk Groups‡
- Auscultation for carotid bruits
- Complete skin examination
- Complete oral cavity examination
- Palpation of thyroid nodules

Laboratory/Diagnostic Procedures
- Nonfasting total blood cholesterol
- Dipstick urinalysis
- Mammogram§
- Thyroid function tests‖

High-Risk Groups‡
- Fasting plasma glucose
- Tuberculin skin test (PPD)
- Electrocardiogram
- Papanicolaou smear**
- Fecal occult blood/sigmoidoscopy
- Fecal occult blood/colonoscopy

COUNSELING

Diet and Exercise
- Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium‖
- Caloric balance
- Selection of exercise program

Substance Use
- Tobacco cessation
- Alcohol and other drugs
  - Limiting alcohol consumption
  - Driving/other dangerous activities while under the influence
  - Treatment for abuse

Injury Prevention
- Prevention of falls
- Safety belts
- Smoke detector
- Smoking near bedding or upholstery
- Hot water heater temperature
- Safety helmets

High-Risk Groups‡
- Prevention of childhood injuries

Dental Health
- Regular dental visits, tooth brushing, flossing

Other Primary Preventive Measures
- Glaucoma testing by eye specialist

High-Risk Groups‡
- Discussion of estrogen replacement therapy
- Discussion of aspirin therapy
- Skin protection from ultraviolet light

CONDITIONS TO REMAIN ALERT FOR

- Depression symptoms
- Suicide risk factors
- Abnormal bereavement
- Changes in cognitive function
- Medications that increase risk of falls
- Signs of physical abuse or neglect
- Malignant skin lesions
- Peripheral arterial disease
- Tooth decay, gingivitis, loose teeth

IMMUNIZATIONS

- Tetanus-diphtheria (Td) booster††
- Influenza vaccine†
- Pneumococcal vaccine

High-Risk Groups‡
- Hepatitis B vaccine

* *From* Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions. *Baltimore, MD, Williams and Wilkins, 1989.* This list of preventive services is not exhaustive. *It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not examined by the task force include chronic obstructive pulmonary disease, bladder cancer, endometrial disease, and prescription drug abuse.*

† *Annually.*

‡ *See text for details about which patients are considered at risk.*

§ *Every 1 to 2 years for women until the age of 75, unless pathology detected.*

‖ *For women.*

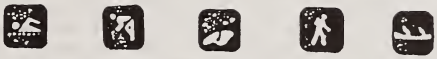
** *Every 1 to 3 years.*

†† *Every 10 years.*

Supplemental submission from Dr. Ureña, testimony 4/16/91 Exhibit 3

A HEALTHY FUTURE:

CAN PREVENTIVE CARE IMPROVE YOUR HEALTH AND QUALITY OF LIFE?



SENIOR HEALTH PROMOTION

GROUP HEALTH COOPERATIVE OF PUGET SOUND
1730 MINOR AVENUE, SUITE 1500
SEATTLE, WASHINGTON 98101-1448

IN COOPERATION WITH

SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE
DEPARTMENT OF HEALTH SERVICES
UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 98195

EXECUTIVE SUMMARY

A HEALTHY FUTURE
COST-UTILITY OF MEDICARE REIMBURSEMENT FOR PREVENTIVE SERVICES IN AN HMO

The major objective of this project is to assess the cost savings and changes in health-related quality of life associated with the introduction and reimbursement of an experimental preventive services package (annual health risk assessment, individual health promotion and disease prevention services, and health promotion group counseling) for Medicare beneficiaries enrolled in Group Health Cooperative of Puget Sound. Hypotheses to be tested are that (1) after 12 months of the demonstration, use of preventive services will increase and use of non-preventive ambulatory services will decrease without significant cost-savings, and (2) after 24 months, the cost per Quality-Adjusted Life Year gained will be significantly lower in the experimental intervention group.

The experimental preventive services intervention is expected to increase health-related quality of life and reduce health care costs through (1) early identification of physical and mental conditions for which there are efficacious interventions available to modify risk factors for disease, disability, and dependency, (2) modification of enrollees' social and physical environment to support health promoting behaviors and maintain or increase independence, and (3) enhancement of enrollee autonomy to function independently and to make critical decisions concerning health behavior and health care. Preventive services are being integrated into HMO activities (1) to increase the perceived value of preventive services for older adults, (2) to target those older enrollees who use the majority of health resources and are at highest risk for health status decline, and (3) to provide efficacious and efficient interventions that will improve health-related quality of life while reducing overall costs of care.

The project is being conducted by the School of Public Health and Community Medicine at the University of washington in cooperation with the Center for Health Promotion and the Center for Health Studies at Group Health Cooperative of Puget Sound. The demonstration is taking place in four GHC medical centers which have about 7,500 Medicare-eligible enrollees who have been receiving primary care services at these sites for at least one year. Enrollees willing to participate have been classified by level of service use (higher users versus lower users) and will be randomly allocated to (a) usual care or (b) experimental preventive services. Higher users are defined as enrollees with 6+ visits in the twelve months prior to enrollment. Higher user enrollees are being oversampled to ensure sufficient numbers for separate evaluation, since this group is expected to benefit to a large extent from the intervention.

The initial number of participants required is approximately 2,250 (1,125 enrollees allocated to each treatment in a ration of 560 higher users to 440 lower users). This initial sample size allows for a 15% attrition in participants every year of observation and 68% power to detect a 35% slowing in health status decline among higher users and a 50% slowing in health status decline among lower users, at the 5% significance level using a two-tailed test.

Prospective participants are being recruited by mail and by phone from lists of enrollees at each site classified by level of service use. Baseline data are obtained through mail questionnaires with telephone follow-up. These procedures provide a comprehensive assessment of health-related quality of life, health risk, self-efficacy for behavioral change, preventive behaviors, social network and support and plans for the future. The major health status outcome measure is the Quality of Well-Being Scale, a component of the General Health Policy Model that will permit an estimation of Quality-Adjusted Life Years for the experimental and usual care control groups. Three other health-related quality of life measures include health worry, general health perceptions, and perceived quality of life. Changes in depression due to the intervention are also being measured. Enrollees who return their informed consent from and complete the baseline questionnaire will be randomized to the experimental and control groups according to service use strata.

The preventive services package consists of a health risk assessment and 15 major interventions: (1) exercise, (2) nutrition, (3) planning ahead, (4) mental health, (5) hearing, (6) medication awareness, (7) incontinence, (8) hypertension, (9) physical exam and laboratory, (10) immunizations, (11) injury prevention, (12) alcohol use, (13) smoking, (14) vision, and (15) breast cancer screening. The package is structured to contain a health promotion component directed toward those risk factors thought to predispose to loss of autonomy or decline in health-related quality of life and a disease prevention component directed toward clinical screening, immunization, and further follow-up of chronic medical conditions and those already detected through the health promotion component. Health risk assessment will be conducted using an assessment guide and protocol developed for this project. Interventions will be guided by risk assessment according to preventive services schematics or protocols developed for each area within the 15 major interventions.

The annual capitation rate for these services is $183.68.

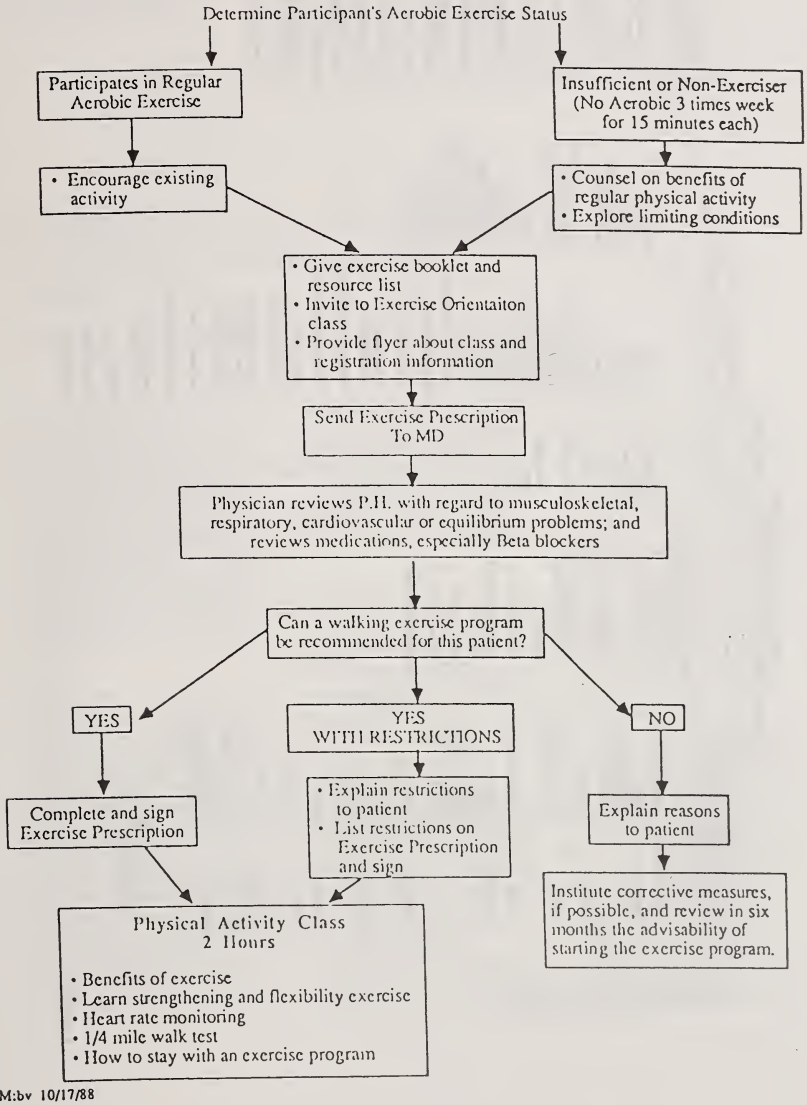
Special record forms have been developed for the preventive services interventions. Utilization data will be gathered primarily through GHC's computerized enrollment and utilization data base systems. Individual health services costs will be calculated for the year prior to randomization and two years following randomization on an annual basis. Total cost for an individual patient on a given visit will be the sum of the per diem base rate for length of visit plus the cost of individual ancillary services associated with the visit. Inpatient costs

will be estimated using a modified DRG methodology. Other unit costs (pharmacy, laboratory and outside services) are directly available from GHC.

Cost-utility analysis will be conducted to compare **costs** (costs of intervention plus costs of treatment incurred because of intervention, minus savings in future medical costs because of prevention) to **effects** (years of life added by preventive services intervention plus improvements in health during years that would have been lived anyway minus any deterioration in health because of the intervention). Quality-adjusted life years will be calculated by integrating the level of health-related quality of life with the expected duration of stay in each level multiplied by preference weights associated with each level. Two discount rates will be use (0 and 5%), and sensitivity analyses will estimate program output using different values of variables in the cost-utility model. Administrative and unintended outcomes will be investigated through special studies. Different methods of calculating Quality-Adjusted Life Years will be explored for different subgroups of participants to identify those who appear to benefit most from the preventive services intervention.

The demonstration procedures have been designed explicitly for replication in other primary care settings. Pragmatic ways of offering preventive services benefits to older adults will be explored in the evaluation. The evaluation measures are largely standardized instruments used widely in health services research and preventive services evaluations. The demonstration and evaluation procedures are comparable to other preventive services evaluations sponsored by the Health Care Financing Administration and other public and private funding agencies.

PHYSICAL EXERCISE



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A HEALTHY FUTURE
SENIOR HEALTH PROMOTION PROGRAM

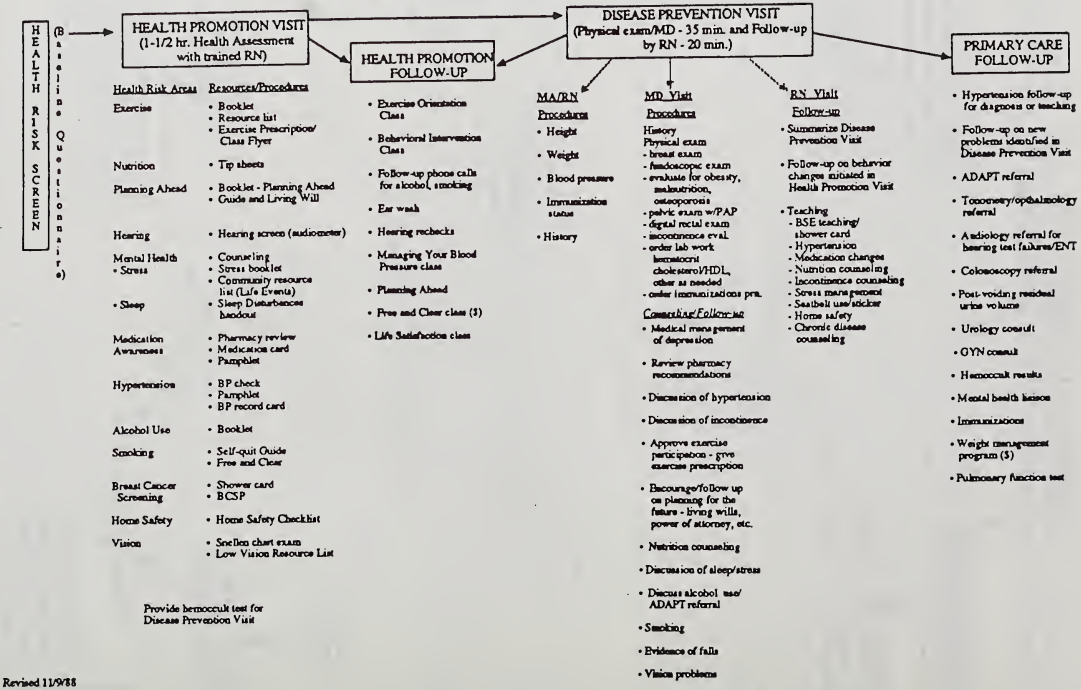

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Exhibit 4

UPDATE
Centers for Health Promotion

University of Washington Center for Health Promotion in Older Adults

Gilbert S. Omenn, M.D., Ph.D.

Three academic institutions—the University of North Carolina, the University of Washington, and the University of Texas—received funds from the Centers for Disease Control in September, 1986, as centers for research and demonstration in health promotion and disease prevention. This article focuses on the University of Washington Center for Health Promotion and Disease Prevention. A future issue of Perspectives on Prevention *will feature the Southwest Center for Health Promotion and Disease Prevention at the University of Texas.*

The University of Washington Center for Health Promotion and Disease Prevention was formed as a joint venture of the School of Public Health and Community Medicine and the Group Health Cooperative of Puget Sound. Ambulatory, non-institutionalized older adults are the target population for University of Washington Center activities. Our objectives are: (1) to identify modifiable risk factors affecting the leading causes of disability, morbidity, and mortality; (2) to develop methodology for overall assessment of health status and changes in health status in relatively healthy older adults, (3) to generate feasible interventions that could help achieve the goal published in *Healthy People* to reduce days of restricted activity by 20 percent to less than 30 days per person per year by 1990; (4) to continue to implement and then evaluate a multi-faceted health promotion demonstration in the large HMO, Group Health Cooperative (GHC) of Puget Sound; (5) to investigate risk factors in a specific cause of disability in the elderly, hip fractures; (6) to reduce incidences of disabling falls and hip fractures by 25 percent in the Demonstration; and (7) to stimulate additional research and demonstration projects.

Ambulatory, non-institutionalized older adults are the target population for UW Center activities.

This multidisciplinary, multi-institutional Center was established in September, 1986, based in the School of Public Health and Community Medicine. As shown schematically in Figure 1, the University of Washington Center has five major types of activities: development of methods, provision of technical assistance, and evaluation; formal case-control study of hip fracture; a comprehensive health appraisal demonstration project in the defined population at Group Health Cooperative; a variety of developmental pilot studies; and workshops, teaching, and dissemination. The Center's activities are coordinated by the Center Director, with major guidance from the Core Faculty, Steering Committee, and Committee of Advisors.

The Methodology Core is co-directed by Drs. William Carter and Edward Perrin, Department of Health Services. In addition to a small research staff, the Core has an extended multidisciplinary faculty with expertise in a wide range of topics (behavior change, biostatistics, economics, epidemiology, evaluation, health status assessment, measurement development, and general psychometric issues). The role of the Core (see Figure 2) is to serve as a resource center for University of Washington Center investigators. Its objectives are: (1) to develop and evaluate mea-

promotion and disease prevention efforts in the elderly, with emphasis on measures of health risk, health status change, and quality of life; (2) to identify and develop methods for improving compliance with health promotion and disease prevention recommendations; (3) to produce critical literature syntheses on selected topics; and (4) to provide technical assistance and operational support to Center research and demonstration projects. In all of these activites, including specific methodologic empirical research projects, there is a close linkage between methodologically-oriented faculty and those involved in the case-control study, the demonstration, and the developmental pilot projects. Such integration is an important feature and an important product of the Center.

The top priority for the Methodology Core during the first year was the evaluation of existing measures of health risk, health status, and quality of life for assessing the impact of health promotion efforts in well older adults. A comprehensive review of the literature yielded few measures that addressed broad enough spectrum of older adults. Even instruments like the Sickness Impact Profile, a comprehensive measure of behavioral dysfunction used in many evaluation of acute and chronic illness interventions, may be inappropriate for well older people. Few older respondents in

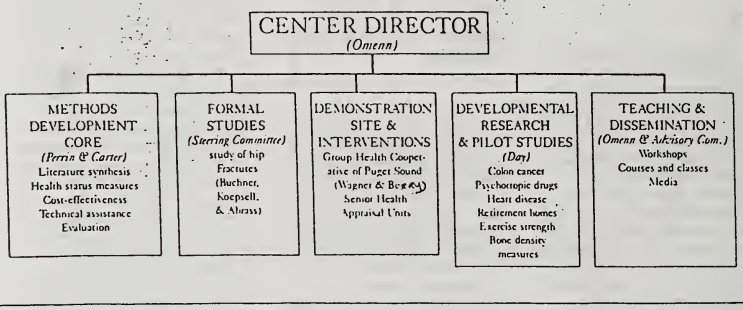
A comprehensive review of the literature yielded few measures that addressed broad enough spectrum of health and illness to be sensitive to all older adults.

surveys respond to items of dysfunction, even if they report chronic conditions. They tend to view their health positively. Nevertheless, it was possible to select potentially useful items and instruments that provide, in the aggregate, a relatively comprehensive assessment package. This questionnaire that will serve as the main assessment tool for the GHC Demonstration, and parts of the instrument will be used in a similar capacity in the Hip Fracture Study.

From this process of evaluating health assessment instruments, critical reviews of the potentially relevant literature on physical activity, mental well-being, functional status and selected physiological functions (vision, hearing, and balance) have been drafted. A special review form and scoring system was developed (adapted from Haynes, Taylor, and Sackett, 1979) for the complex and often incomplete articles in the relevant literature. Data from the review forms are entered into an automated database which should facilitate access and future dissemination of this information. Currently, more than 2400 potentially relevant bibliographic references have been entered.

The *Group Health Cooperative Demonstration* is co-directed by Drs. Edward Wagner, Director of the Group Health Cooperative (GHC) Center for Health Studies and Professor of Health Services, and William Beery, Director of the GHC Center

Figure 1: Structure of the UW Center on Health Promotion & Disease Prevention in the Elderly



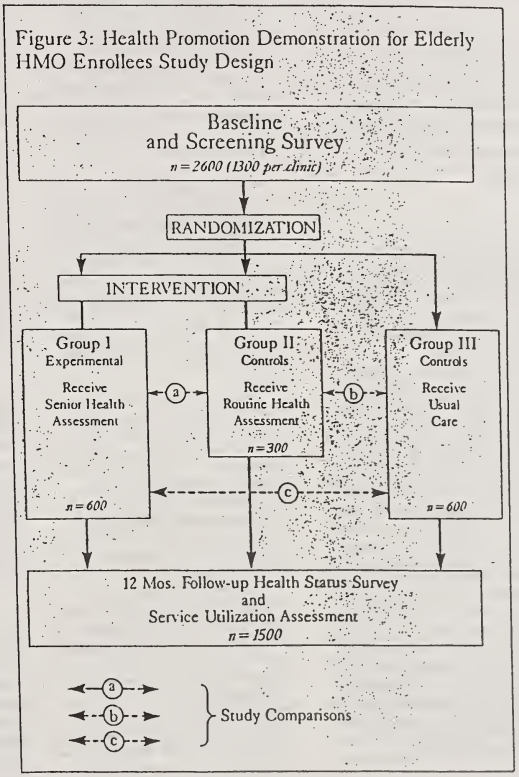
pharmacist will review both the pharmacy profile and symptom checklist of seniors taking the targeted classes of drugs, and will develop specific guidelines reducing doses and/or eliminating offending agents. The pharmacist will convey the recommendations from their drug/symptom review to the primary care team for review and action.

3. *Home Safety*: The home safety intervention is intended to prevent accidental injury by providing subjects with home safety checklists and, for those at high risk, a home safety inspection. The intervention was developed by Center for Health Promotion (CHP) staff under the direction of M. Gray and is supported by the Group Health Foundation. The intervention relies on the use of senior volunteers, recruited from the GHC senior population and from local corporations, to conduct a home safety inspection for those at high risk of injury (over 75 years of age or with a fall in the past year). Subjects at lower risk of home injury will receive a home safety checklist and list of safety resources, with suggestions for changes to decrease environmental hazards in the home. Volunteers will phone these subjects, providing information and reinforcement for making changes. High risk participants will receive a home safety inspection by senior volunteers. The specially developed home safety checklist will identify hazards, make recommendations for repairs, make simple modifications such as adjusting hot water heater temperatures and replacing smoke detector batteries, and provide information on HGC and community resources for home repairs. The high risk subjects will also receive telephone follow-up by senior volunteers.

4. *Hearing*: The hearing intervention is being developed by Dr. Richard Uhlmann of the Division of Geriatrics at University of Washington and colleagues in the Department of Audiology, with the assistance of S. Mielchen of GHC. All experimental group subjects will be audiologically screened for hearing impairment. Hearing impaired seniors will then be randomly assigned to either usual care or a behavioral intervention. The latter entails a series of classes designed to assist hearing impaired seniors improve functioning by changing their behaviors as listeners to position themselves for more favorable acoustics and to make them more assertive.

5. *Physical Activity*: A physical activity intervention has been designed by GHC (S. Mielchen) in collaboration with Dr. Eric Larson of the University of Washington. The intervention focuses on increasing cardiovascular fitness, flexibility, and leg strength. This program, like the home safety program, will utilize senior volunteers to instruct and guide activity groups. The activity levels of all subjects in the intervention group will be reviewed at the time of their visit. Seniors determined to be active will receive support for continuing their current exercise program, and may be recruited to serve as volunteer

Figure 3: Health Promotion Demonstration for Elderly HMO Enrollees Study Design



leaders for one of the physical activity options for the not-fit group (described below). Seniors classified as inactive will be invited to attend an exercise orientation session given by health care providers including a physician and CHP staff. The orientation will provide a low-level fitness test and information on various exercises to increase flexibility and muscle strength. It will also introduce options for increasing activity and cardiovascular fitness, including senior aerobics, community referrals, and most importantly, walking groups led by volunteers from the "fit" group. Walking groups will meet regularly with volunteer leaders and will be trained and supported by health educators from CHP. Telephone follow-up will be provided.

A working group of experts in geriatrics and alcohol have developed an intervention plan which targets the problem drinker.

The *Case Control Study of Hip Fractures* is headed by Dr. David Buchner, together with Dr. Thomas Koepsell and Dr. Itamar Abrass of the University of Washington. The aim of this study is to elucidate risk factors for hip fractures in older adults. Hip fractures and other fall-related injuries represent a large public health problem. Over 210,000 hip fractures occur each year, with 84 percent sustained by adults over age 65. By age 80, the estimated lifetime risk of hip fracture is 15 percent for white women and 5 percent for white men; by age 90, up to 33 percent of women and 17 percent of men have suffered a hip fracture.

Previous case control studies of hip fracture have usually been retrospective, comparing hospital controls with hospitalized hip fracture cases. In contrast, the population-based study in the Group Health Cooperative HMO enrolls cases prospectively, collecting risk factor data soon after the hip fracture occurs.

An important component of this study is to clarify *how* risk factors act. Risk factors for hip fracture could affect the risk of sustaining a fall, or the risk of fracturing a hip after a fall, or both. Clarifying how risk factors act requires comparing fallers who fracture to fallers who do not. In order to make these comparisons, a large control group has been enrolled as a cohort which will be followed for 2 years. Fallers will be identified by a surveillance system which contacts patients at least monthly to check whether they sustained a fall in the past month. Risk factor measurements on fallers are taken soon after the fall. Control subjects who do not fall have risk factor measurements done at a random time during the 2-year follow-up.

A particular interest of the study is muscle strength. Muscle activity, along with weight-bearing, appear to be the most important determinants of bone strength. A device primarily used in sports medicine clinics, the isokinetic dynamometer, will be used to measure leg strength in the study. Also, a new physical activity measurement tool, appropriate for older age groups, has been developed for the study.

Other risk factors measured by the study include estrogen use, dietary calcium, alcohol use, smoking, fluoride exposure, sunlight exposure, and health status. At the clinic visit, measures of skin fold thickness, balance, gait, vision, hearing, cognitive status, handgrip strength and leg muscle strength are performed. Bone density is measured using a dual-energy photon absorptiometer.

Based upon feedback from the Centers for Disease Control, the study was enlarged to collect pilot data on the effect of environmental hazards on hip fracture risk. Of particular interest to the study is the measurement of coefficient of friction. After inspecting the shoes the subject was wearing at the time of the fall, senior volunteers go to the scene of the fall and measure how easily the shoes slide across the surface. They also measure the hardness of the surface using an inexpensive fixed "g" accelerometer. Hopefully, these data will help answer an obvious question about hip fractures: do adults who fall and fracture simply land on slick and harder surfaces than adults who fall and do not fracture?

Preliminary results of the study indicate several interesting findings regarding the participation of older adults in research studies. First, surveillance of the control group for falls has required that all controls mail monthly postcards to the study office stating whether they have or have not had a fall. This surveillance system is working remarkably well, with a non-compliance rate of less than 20 percent. Second, older adults appear able to report their physical activity reliably in some detail. Third, analysis of the intra-subject variance in strength measures suggests that subjects are providing true maximal efforts during strength measurements. Fourth, seemingly minor changes in the recruitment process had important effects on recruitment. Thus, approaching adults over age 80 for participation in research studies may require considerable attention to detail. Finally, recruitment has shown that the etiologic fraction of hip fractures due to dementia may be larger than generally appreciated.

The home safety intervention is intended to prevent accidental injury by providing subjects with home safety checklists and, for those at high risk, a home safety inspection.

Developmental Projects. Several pilot projects have been stimulated and initiated with seed money allocated from a developmental research fund by the Center Steering Committee. The developmental projects are di-

verse, including: analysis of residential communities of older adults in the Northwest to determine potential interest and suitability for participation in future studies; linking the database on certain classes of medications in the Group Health Pharmacy files to the separate database on medical utilization and health care status for the population; correlation of bone histology with bone density measurements to buttress the use of non-invasive techniques in the hip fracture case-control study and other studies; development of an intermediate endpoint involving the pattern of cell-proliferation in biopsies from mucosa of the colon, which would permit practical studies of the effects of activity, calcium, and fiber on the risk for colon cancer; and extensive analysis of the database for which the University of Washington Department of Biostatistics provides the Coordinating Center for the NHLBI Coronary Artery Surgery Study (CASS) to test whether the risk factors that have been identified as important in middle-aged persons are still important in the 60+, 70+ age groups and to determine whether reduction in those risk factors has the expected salutary impact on their health status and frequency of adverse health outcomes. Preliminary data from the CASS analysis suggest quite favorable findings outcomes in older persons from stopping cigarette smoking.

Finally, recruitment has shown that the etiologic fraction of hip fractures due to dementia may be larger than generally appreciated.

Dissemination. In conjunction with our external Advisory Committee, we have conducted a public workshop in September, 1987. Further activities are planned during the second year. Inter-Center workshops, publications and presentations at PREVENTION 88, gerontological, and other meetings are important avenues for dissemination, as well.

References

1. *Principal Investigator*: Gilbert S. Omenn, M.D., Ph.D., Dean, School of Public Health and Community Medicine.

Co-Principal Investigators:

Methodology Core: William Carter, Ph.D., Associate Professor, Department of Health Services.

Edward Perrin, Ph.D., Professor and Chairman, Department of Health Services.

Hip Fracture Study: David Buchner, M.D., M.P.H., Assistant Professor, Department of Health Services.

Thomas Koepsell, M.D., M.P.H., Associate Professor, Director, Community Medicine Program, Department of Health Services.

Itamar B. Abrass, M.D., Professor of Medicine, Head, Division of Gerontology and Geriatric Medicine, Harborview Medical Center.

Demonstration Project: Edward Wagner, M.D., Director, Center for Health Studies, Group Health Cooperative; Professor, Department of Health Services.

William Beery, M.P.H., Director, Center for Health Promotion, Group Health Cooperative.

Developmental Projects: Robert W. Day, M.D., Ph.D., Professor, Department of Health Services, Director, Fred Hutchinson Cancer Prevention Center.

Exhibit 5

HEALTH PROMOTION AND DISEASE PREVENTION
CLINICS IN GERIATRIC MEDICINE (Feb., 1992 issue)

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Gilbert S. Omenn, Itamar Abrass, Eric Larson, Ed Wagner, Editors

Chairman STARK. Thank you very much.

I have just been notified that there is a scheduled vote. If the witness will excuse me, I will go over and vote and come back as quickly as I can. We will proceed at that time.

[Recess.]

Chairman STARK. I apologize, for the delay. Dr. Brody has indicated he may have to leave, and because I know how he feels in regard to Medicare, before I recognize Dr. Steinwachs, I will ask you a question very quickly.

Obviously, my idea of a screen test was not original, but as you know, as all my college professors know, I will plagiarize anything if it will help the cause. I would like you to later on, if you can, just submit to me, from the standpoint of ethics, or your opinion as a physician in terms of whether or not people would respond to this. Could we politically, ethically, in the context of how America relates to health care and Federal regulation, could we require, considering that part B is voluntary, some level of screening upon entry?

Now, when I was a kid in school, we lined up to have our patch tests and all the rest. I was never sure—maybe I could have objected. I never tested it. But we took our sugar cubes with the drops of stuff on it, and people rushed to do that. Is there any reason we can't do this? It would seem to me to be tremendously inexpensive, and lead at least to a baseline that would save money, if not lives.

Dr. BRODY. My opinion, I started that way because it is my opinion, is that the public is very health conscious, and as they grow older they become more health conscious. If presented in a palatable way, we have certain streams that older people join into. If you want to have your drivers license renewed, you have to go to an authorized facility that also requires you to take a vision test.

Chairman STARK. Precisely.

Dr. BRODY. If you are an 80 or 40——

Chairman STARK. Be it an air traffic controller or a train driver, you have to have a urine test.

Dr. BRODY. In Chicago, health promotion projects that are carried out in tough neighborhoods. We were not satisfied that Pap smears were being sufficiently utilized, so we had to get to the right people at the right level. Initially, it is labor-intensive to start up such a project.

Schools of public health are figuring out ways to reach hard-to-reach populations. We are following 1,000 street intravenous drug users and they come back each 6 months. So it is possible.

Chairman STARK. One final question.

In your opinion, is there any relationship that you can establish between what we pay in a fee and the number of people that will decide to go and be screened or tested?

Dr. BRODY. It is such a complex issue. The populations that we want to reach with this legislation are those who aren't fee conscious; they are access conscious. The other people we handle in a different way. We put it on TV or something like that, and they come in because they get frightened. But there is this subgroup that is so visible in the cities, as well as rural areas that are far away from sources of, from true access. So once we have defined a

target population, I think we have a real cost effective shot. There is an initial cost intensive period because of the manpower.

Chairman STARK. Thank you.

Are there any other witnesses who want to plead precedence over another witness because of a pressing time schedule?

If not, I will call on Dr. Steinwachs, and suggest that Dr. Brody leave at any time that he must.

Are you comfortable with that? OK.

Proceed, Dr. Steinwachs.

STATEMENT OF DONALD M. STEINWACHS, PH.D, DIRECTOR, HEALTH SERVICES RESEARCH AND DEVELOPMENT CENTER, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

Mr. STEINWACHS. Thank you, Mr. Chairman.

I am Don Steinwachs. I am director of the Health Services Research and Development Center of the Johns Hopkins School of Hygiene and Public Health. I appreciate the opportunity to appear before you today in support of the Medicare Preventive Benefits Act of 1991.

I would like to summarize a few major points and share with you some of what is being learned at one of the Medicare demonstration sites at Johns Hopkins University in Baltimore. You authorized the demonstrations in 1986 to begin to provide you with information, as well as the Congress and the administration, about the effectiveness and the cost of a Medicare preventive services package.

I would also like to offer to you and the committee two recommendations for your consideration, one that involves a more active role for Medicare in promoting preventive services, and you, Mr. Chairman, have already addressed pieces of this; and the second is to recommend an ongoing evaluation of the effectiveness of those services being covered.

I don't need to tell you about the burden of disease the elderly face, but I did want to point out something that I think we all appreciate, that extending years of life is very important as part of preventive services. But we should also remember the value of preventive services is also to improve the quality of life. There are many things that the Medicare program pays for now, such as cataract surgery—about a million a year—that have no impact that I am aware of on length of life, but certainly have an impact on quality of life.

And as some of the previous speakers have said, it seems to me we ought to have equal scales to measure curative services in terms of whether or not they ought to be covered. We ought to measure preventive services on a similar set of scales and measure both the duration of life as well as the quality of life.

One of the demonstrations in the Medicare demonstration program is in Baltimore and we have had an opportunity to begin to answer some of the questions I think you and the committee want to know about. We are just now finishing the first 2 years of providing preventive services and are obtaining the followup data now.

I would like to share some preliminary findings because I think they bear on some of the issues you are talking about today.

One thing we were uncertain of and that was physician participation. In the Baltimore area, we approached 120 physician practices and asked them to participate in a preventive services demonstration. Certainly there was reimbursement going with this, this wasn't for free, but 85 percent agreed to do so, and I think this reflects a high level of enthusiasm in the practicing community.

That is important. As you get experience from the demonstration sites, you are going to get experience with different kinds of delivery models. We have had experience with hospital-based, clinic-based and community-based private physican models. Other sites are using nonphysician practitioners. I think similarities and differences will be important to understand as we look at the economic as well as the effectiveness of a program.

Also, we need to look at who uses the services. Sixty-seven percent of the elderly have shown up for at least one visit during this period.

Chairman STARK. Do you advertise?

Mr. STEINWACHS. What we did was we approached—it was roughly 4,400 Medicare eligibles and asked them if they would agree to be interviewed, and they did. We collected base-line information, and we randomized them into an intervention group or a control group. The intervention group was offered the chance to go to their doctor and have a covered preventive visit on an annual basis that included both screening services and counseling.

Sixty-seven percent showed up for at least one visit in this 2-year period. Importantly, there was no significant difference by age. The 85-year-old and older group showed up as frequently as the younger group. There was no significant difference by race. There were marginal differences by sex. In fact, males were a little more likely to show up than females.

Chairman STARK. Does this include the clinic in Owensville?

Mr. STEINWACHS. No. This is really eastern Baltimore, northeast, and goes out into Baltimore County.

Chairman STARK. They have a good idea down there. They have the clinic next to the post office.

Mr. STEINWACHS. Like one-stop shopping, sounds excellent.

We also looked at use by income and you do see some significant differences by income. Fifty-nine percent of Medicare households with an income of under $5,900 a year participated, as compared to 72 percent with incomes over $25,000. I think the important point to walk away with here is that a majority of the poor elderly did come in and use the services.

Chairman STARK. Does your information indicate anything about those who didn't come, and if so, did the respondents express any concern about cost?

Mr. STEINWACHS. Well, one of the things that is part of this experience and needs to be compared to other experiences is that the preventive services were being fully paid for. They were not subject to deductible or coinsurance. So there was no financial disincentive for the Medicare beneficiary no matter what the income was to use services. When you look at situations that do have copayments or deductibles, then you are going to expect a lower rate of use. This provides an optimistic estimate of what could be done, that is, two-

thirds of the population age 65 and over showed up for a preventive visit.

We have not yet gotten to the point where we can tell you exactly what kinds of new conditions were found and so on, but it is interesting that we have gotten several letters. One in particular from a grateful patient, who wrote in. She told us that if it had not been for this preventive services visit—she did not have another appointment with her doctor for a number of months and he found she had bleeding in the bowels. They found a polyp that was malignant, and took it out, and she feels it saved her life. This was one case. We soon expect to be able to tell you more.

This preventive services demonstration also addresses health risk in which there are areas a physician can counsel a patient.

We did find out something about health risk by surveying the elderly. We found 65 percent worried about their health; 46 percent reported getting little exercise; 32 percent reported they were overweight; 21 percent reported on multiple prescriptions; 15 percent reported they were smoking; 14 percent reported that during the past year they had suffered a fall or a burn, and again, these are areas in which prevention can have an impact.

One of the questions that I think this committee, the Congress, and the administration will be facing is whether or not you ought to fund a preventive services visit as differentiated from individual preventive tests and immunizations. One of the opportunities you have with the demonstrations you have already authorized is to look at what happens when you have a visit versus what happens if you don't have a visit. If you fund only the individual services you are relying on physicians to remember when being seen for a specific problem, whether you had mammography; oh, yes, have you had screening procedures. This leads me to two recommendations that I would briefly like to summarize for you.

One is, it seems to me, that this committee and you, Mr. Chairman, have taken the leadership in raising issues of medical effectiveness and the need for ongoing evaluations of the effectiveness of care paid for by Medicare. There ought to be an ongoing evaluation of the effectiveness of medical services covered under Medicare which can provide reports on who receives preventive care services and at what intervals, which physicians provide them, what stage of the disease are problems being identified, and what are the estimated benefits and costs of what Medicare covers. Certainly, this could be done through an annual summarization of the Medicare claims files and by having the PROs sample a set of charts and bring back to you information on what is being found as part of those preventive services. I would hope this could become an expanded package.

A second thing I hope we know and appreciate is that insurance coverage of preventive services is necessary, but it is not sufficient. You have to educate both providers and beneficiaries as to the fact they ought to want and demand to benefit from preventive services. I would recommend for consideration by you and the committee that Medicare take an active role in promoting preventive services, and one way to do this would be by developing and disseminating on a regular basis preventive care practice guidelines and,

again, to build on a model that you have already put forward on practice guidelines.

Chairman STARK. Do you know how bad we are? You have 2½ million seniors below $6,000 in income who could save $360 a year. They don't have to pay their part B premium, if only they would click into Medicaid. But we are not getting the word out. If you can't get someone who is so poor as to live on $500 a month to save $30 a month, that is the dilemma. The outreach system is not very good. I don't know why, but it isn't. If we can't give money away, it is going to be a lot harder to give these tests.

Mr. STEINWACHS. If you get the information out there, people will make use of it.

Let me just thank you very much, Mr. Chairman, for the opportunity to be here today, to share with you both some of the things we are learning from the demonstrations you authorize, as well as to provide you with two recommendations on active role for Medicare and on ongoing assessment of the preventive services under Medicare.

[The prepared statement follows:]

TESTIMONY OF DONALD M. STEINWACHS, PH.D., DIRECTOR
HEALTH SERVICES RESEARCH AND DEVELOPMENT CENTER
SCHOOL OF HYGIENE AND PUBLIC HEALTH
THE JOHNS HOPKINS UNIVERSITY

Mr. Chairman and members of the Subcommittee, I am Donald Steinwachs, Director of the Health Services Research and Development Center of the Johns Hopkins School of Hygiene and Public Health. I appreciate the opportunity to appear before you today to testify in support of the Medicare Preventive Benefits Act of 1991 (H.R. 2565) introduced by Representative Rostenkowski and co-sponsored by members of the Committee.

This legislation recognizes the importance of preventive care in adding years of useful life for older Americans. I fully support its objectives: to expand Medicare coverage of preventive services, to authorize demonstration projects to evaluate the appropriateness of additional preventive services, and to establish a systematic process for determining when other preventive services should be covered under Medicare. In my testimony I would like to share with you some of what is being learned in one of the Medicare Prevention Demonstrations you authorized in 1986. From this experience, and what has been learned more generally about preventive care, I will propose two recommendations for your consideration: (1) to broaden the legislation to have Medicare take an active role in promoting the use of preventive services, and (2) to instruct the Health Care Financing Administration to establish an ongoing evaluation of the effectiveness of covered preventive services in improving the health of the elderly.

Since the enactment of Medicare in 1965, significant scientific advances have been made in the identification of health risks for which preventive services can be effective in extending the duration and quality of life. The Medicare Preventive Benefits Act of 1991 draws on this growing body of knowledge in recommending the expansion of covered preventive services to include cholorectal cancer screening, annual mammography, well child care, and influenza and tetanus-diphtheria vaccinations. I particularly support the establishment of an ongoing process for evaluating additional preventive services to determine what works, at what cost, and to identify what should be recommended to Medicare for coverage.

As the Committee knows, the objective of preventive services is to extend life through the prevention and early detection of disease. For the elderly, priority has to be given to preventive services that will maintain and improve the level of functioning which directly affects the quality of life. The 1990 Objectives for the Health of the Nation recognized this priority when it proposed "to improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20%, to fewer than 30 days per year for people aged 65 years and over." Preliminary data in Health U.S. 1989 suggest we have almost achieved this objective. However, it also provides disturbing data that there has been no substantial decline in the average of 14 days spent in bed each year due to illness or injury. Remember we are talking about America's elderly losing over one month out of every year when they cannot participate in usual activities, two weeks of which they are confined to bed. This is the current burden of disease and injury, and it is a very heavy burden.

The Year 2000 Objectives for the Nation recently issued by the Departmenmt of Health and Human Services strongly moves us forward in the emphasis on health promotion and disease prevention "to improve health and well-being."

How do we decide what Medicare should pay for?

Preventive services are recognized as a key element in reducing disability and lengthening life. However, this Committee is well aware of the controversies over the cost of preventive care and who should pay. Some argue that preventive services should be covered only if it can be shown that they will lead to overall cost savings for Medicare, for example prevent costly hospital admissions. It is reasonable to expect that preventive services can reduce the frequency of some hospitalizations and the intensity of care required. Yet, we should not demand of prevention a standard of cost savings that is not also demanded in making coverage decisions for diagnostic and curative services.

A more appropriate standard is whether the cost of preventive care for each additional year of life added is commensurate with what Medicare is paying for additional years of life due to curative services. Such calculations for preventive services have been done by the Office on Technology Assessment of the Congress. However, in doing such calculations it should be remembered that quality of life has to be taken into account; it is not sufficient to simply extend life. Indeed, much of medical care is not intended to extend life, but to improve or maintain its quality, e.g., Medicare pays for a million cataract surgeries each year that save and restore eye sight but cataract surgery has not been shown to extend life. Thus, it should be sufficient to show that preventive services substantially improve the quality of life at a price that is equal or less than what is paid for curative services.

What information is needed to make policy decisions?

There is a wide range of information needed to make decisions regarding preventive services coverage. After we have evidence that the preventive service is effective in improving quality of life, adding years of life, or both, we need answers to questions that affect implementation and budgeting for preventive services. These questions include:

- Will physicians participate in a preventive services program for their Medicare patients?
- Who among Medicare beneficiaries will use covered services, how frequently, and who benefits?
- What are the costs to Medicare and to the beneficiary?

In 1986, this Committee authorized five Medicare Preventive Services Demonstrations as a means to provide answers to some of these questions. Most of the demonstrations did not actually begin until 1989, but I would like to share with you some of the early findings from the Johns Hopkins Demonstration being conducted in Baltimore under the leadership of Dr. Pearl German. I believe this will illustrate the value of demonstrations as a method for answering policy implementation questions.

Will physicians participate in a preventive services program?

The answer in Baltimore is a resounding yes. Among 120 community, hospital-based, and clinic-based physician practices, over 85% agreed to participate and actually have provided services in the demonstration. Most of the physicians were willing to participate in a continuing education program to learn about prevention in the elderly and about counseling.

Which elderly use preventive services?

Two-thirds (67%) of those offered a preventive services examination have received at least one over the two year demonstration. It is noteworthy that we have found no differences in preventive services participation rates by age; similar proportions of these 65-74, 75-84, 85 and over received these services (64%, 66%, and 60%). Small differences were found by sex, with males more likely than females to receive a preventive visit (69% vs. 62%). No statistically significant differences were found by race, but non-whites were somewhat more likely to have a preventive visit (70% vs. 64%).

Differences were found by household income; 59% of those with annual household incomes under $5,500 received a visit, as compared to 72% for those with incomes over $25,000. The difference is statistically significant but it is noteworthy that an appreciable majority of the poorest of the elderly responded to our message about preventive care and made a visit.

There are also differences by education, but not as large as those by income. We found that 62% of those who had not gone to high school received the preventive care, while 69% of those completing high school or higher education received the care.

Overall, we have found that a majority of all Medicare beneficiaries value preventive services sufficiently to take their time to make an appointment and see their physician.

It is important to note that this demonstration paid the full cost of preventive services, and the beneficiary did not have to pay a deductible or any coinsurance. If there had been out-of-pocket payment, I am certain the participation rates would have been substantially lower. The full financing of preventive services should be seriously considered, otherwise research evidence, such as the RAND Health Insurance Study, tells us that participation will be lower and health benefits of prevention will be less. Concern has to be for the poorer elderly who will face substantial financial barriers to access. Also, we should be concerned for the numerous elderly who are less knowledgeable regarding the benefits of preventive services and will be unwilling to pay for services they do not fully understand.

What is being found in the comprehensive preventive examinations?

It is too early to be able to tell you exactly which conditions are being identified, or to estimate health status benefits. This information will start becoming available within a year. However, I would like to quote a letter from Helen Eastip of Baltimore who wrote to us, " I want to thank you all for sending me a letter to have a check up with my Family Doctor. I have already set up a date for my follow up. But I am writing to let you know if you had not sent me the letter I did not have an appointment until Feb 1990 which would have been two late (for) me. I was bleeding in my bowels and went to the hospital (and) had a check up. They found a siss (cyst) and took it off. It had cancer in it, but it was just starting so they got it all. So thank you for my life." Preventive services may not always be so successful as they were for Helen Eastip, but this is an example of what can be achieved. The proposal to cover colorectal cancer screening directly addresses what Helen Eastip needed.

What are the elderly's health risks appropriate for physician counseling?

The elderly face a range of potentially preventable risks that are appropriate for physician counseling. In Baltimore, we found the following potential risks:

- 55% of elderly report worrying about their health,
- 46% report getting little exercise,
- 38% report poor physical functioning,
- 32% report being overweight,
- 21% report taking multiple medications,
- 16% report sleep problems,
- 15% report smoking, and
- 14% report experiencing a fall or burn in the past year.

Physicians can assist in all these areas by providing education, advice, and where appropriate a referral for services. Each of these risks can have significant consequences for the health and quality of life of the elderly person. It is important to note that many of the elderly have multiple risks. These risks can be eliminated or potentially adverse consequences can be controlled through effective preventive interventions.

What does a comprehensive preventive services visit cost?

The demonstrations were designed to determine the cost to Medicare of a preventive services package, including the cost of services resulting from preventive examinations, including diagnostic tests and referrals. The demonstration in Baltimore enrolled 4400 elderly, a random half were offered

preventive services coverage and the other half were not. A comparison of Medicare payments for the preventive services group to the control group will soon provide answers to the short-term costs of routine preventive visits.

It will require longer term tracking of these two groups to identify future cost savings that result from early detection and treatment of disease, and from physician counseling on health risks. The Committee authorized an extension last year to make this possible.

What are the benefits of specific preventive services?

The demonstrations you have authorized will be providing some of this critical information. As proposed in the legislation, there is also a need to carry out a series of new demonstrations to evaluate additional preventive care service. The current demonstrations will not be sufficient to address all the questions faced in policy implementation.

A major policy question is whether or not the coverage of individual preventive services is sufficient or does there need to be a special visit at which comprehensive preventive care is provided? The proposed demonstrations under this legislation will provide an opportunity to compare coverage of individual services to the approach taken in the current demonstrations to pay for a preventive visit, plus the individual services. This is a central policy implementation issue. Specifically, if there is no coverage for a periodic preventive visit under Medicare, when will Medicare beneficiaries receive the covered immunization and screening services? This may be a greater problem for those who perceive themselves to be relatively healthy and are not seeing a doctor frequently. Demonstration experience can begin to help us answer this question in addition to others.

Is the Medicare preventive services coverage effective?

The Committee has provided leadership in raising fundamental questions regarding medical effectiveness and the contributions to improve patient outcomes of medical care and surgical procedures. Furthermore, the Committee has supported the development and dissemination of practice guidelines to improve the effectiveness of medical care. A similar set of issues are faced in preventive services.

I propose for your consideration a **Medicare Preventive Services Effectiveness Evaluation** to address issues of effectiveness through an ongoing evaluation through Medicare's experience. The purpose would be to provide Congress and the Administration periodic reports on:

- Who receives preventive services among Medicare beneficiaries and at what intervals;
- Which physicians provide them and which do not;
- What diseases and at what stage of progression (severity) are they being identified; and
- What are the estimated benefits from preventive services covered (e.g., years of life added and improvements in quality of life), and what would be achieved if the preventive services reached more of the Medicare beneficiaries?

This should represent an ongoing assessment of the effectiveness of preventive services that will assure Americans that their money is being well spent and that those who could benefit from services are receiving them.

Implementation of the proposed Medicare Preventive Services Effectiveness Evaluation plan would require routine summarization of Medicare claims to identify who received specific services, at what interval, and who provided them. In addition, a sampling of medical records by the Professional Review Organizations would be required to determine if new problems or conditions are being identified as a result of preventive services, and the

severity and outcomes of care for those diagnosed with specific diseases (e.g., breast and cholorectal cancer). Specific indicators of success would include findings that colorectal and breast cancers are being identified more frequently while the tumors are localized and before they spread. Other indicators of success would be a lower rate of diagnosed pneumonia and influenza, as well as fewer hospitalizations and deaths associated with each.

These indicators can be used along with research evidence on survival rates and quality of life to estimate health benefits. This would provide ongoing information to monitor the effectiveness of the Medicare investment in prevention.

Another reason that monitoring is important is that we have found repeatedly that **insurance coverage is necessary to promote the use of preventive services but it alone is not sufficient.** Physicians and Medicare beneficiaries have to be educated as to the benefits of prevention, and the beneficiaries have to be reminded periodically to use preventive services.

In the past Medicare has not taken an active role to promote utilization, but has attempted to control inappropriate utilization. In prevention, it is critical that appropriate utilization also be encouraged. To accomplish this Medicare must take a leadership role in educating beneficiaries and assuring provider participation. **Preventive care practice guidelines should be promoted by Medicare and widely disseminated to beneficiaries and physicians.**

CONCLUSION

In closing, I want to thank the Committee for the opportunity to share my understanding of the importance of preventive services in the elderly. I, furthermore, want to congratulate Representative Rostenkowski, you Mr. Chairman, and other members of the Committee for introducing the Medicare Preventive Benefits Act of 1991 (H.R. 2565). The legislation is well conceived and if enacted, will take a major step forward to improve the health status of Medicare beneficiaries.

In my comments, I made two suggestions for enhancements in the legislation.

- First, I recommend the Committee authorize a Medicare Preventive Services Effectiveness Evaluation to monitor the use and effectiveness of all covered preventive services.

- Second, I recommend that the Committee mandate the dissemination of preventive services practice guidelines to physicians and beneficiaries on a regular basis.

I hope these suggestions will be useful to the Committee, and again thank you Mr. Chairman and the Committee members for the opportunity to appear before you on an issue of great importance to the Nation's health.

Chairman STARK. Dr. Skyler.

STATEMENT OF JAY SKYLER, M.D., PRESIDENT-ELECT, AMERICAN DIABETES ASSOCIATION

Dr. SKYLER. Mr. Chairman, thank you for the opportunity to be here. I am Jay Skyler. I am professor and codirector of the Behavioral Medicine Research Center at the University of Miami and president-elect of the American Diabetes Association.

As you are well aware, diabetes is not only an important disease in its own right, but is the leading cause of blindness and amputation in this country and a major cause of heart attacks and strokes as well. The important issue is that all of those complications of diabetes are preventable to a greater or lesser degree and we are not taking advantage of the opportunity to try to lessen the burden of this disease.

You have already implemented some demonstration projects which deal with this. One is the therapeutic shoes program which may very well prove to be beneficial in terms of lessening the frequency of amputation. Whether we will have enough data at the time and point where that is supposed to close, to really answer that question effectively, remains to be seen, and the period may be too short, as was mentioned many times earlier in this hearing today.

Some of the expense occurs early, and the benefits are achieved much later. And that is a different problem for you to face in thinking about expanding other demonstration projects as well to be sure they have an adequate time frame. And we urge you to do that, as we encourage you to continue to look at demonstration projects in a variety of areas.

There is one other area I want to touch on today that is critical and that you have addressed in the past in dealing with the problem of diabetes, and that is that many of the complications can be lessened by careful attention to patients self-care and paying attention to the control of their blood sugar and overall good health habits. Dr. Roper mentioned earlier today during his testimony, the way to encourage that is to provide effective self-care for the patient.

In point of fact, you have previously authorized outpatient education programs to occur in the hospital and rural care settings. Unfortunately, what you authorize isn't always implemented. It needs to go through several layers of bureaucracy, the central office in Baltimore, the various regions, and the intermediaries. It turns out this service is not being widely implemented in many parts of the country as it is, even though you have authorized it.

I think that is one problem that we need to figure out a way to address so that services you do provide can be implemented on a wide-scale basis. The other problem with that is that it is approved at the moment only in the hospital and rural care settings, and most patients achieve their services in the primary care setting not necessarily only in rural areas. And when services are provided at the hospital level instead of at the primary care setting, sometimes they are much more expensive and, therefore, also don't get implemented.

So the second part that I would urge you to do is not only assure that the services you authorize are implemented but provide them in all the appropriate settings, not just to a restricted number of settings, and that particularly applies to this particular one because I think it can and does decrease the impact of all these complications, and you heard that earlier today from Dr. Roper, as well. And I would echo his voice on that. I think it is a different issue. You have heard it several times today, because if we look—and many folks have mentioned that Blue Cross has authorized preventive services, and it was just in the newspaper yesterday—but they too have 58 affiliates, and it turns out for many services that we are familiar with diabetes, the national Blue Cross-Blue Shield may recommend they be implemented, but only a majority of the affiliates actually do so. I will be interested to see how many actually do implement preventive services that got such high media hype yesterday. I bet it is going to be far fewer than we would be hoping for.

And the problem pervades the private sector, not only in Blue Cross and Blue Shield, but generally. Many of our private providers are interested in this quarter and this year's bottom line. And the benefits are achieved years down the line on somebody else's watch, so they really don't implement it in the private sector, either.

There is a message there. I think that you and your committee are in the forefront in trying to implement preventive services through Medicare. We compliment you on that, and on the contents of this particular bill. We hope you will pay attention to some of the issues that I have raised in terms of being sure they are implemented.

I am here to speak in favor of the bill and I thank you for the opportunity to do so.

[The prepared statement follows:]

TESTIMONY OF JAY SKYLER, M.D., AMERICAN DIABETES ASSOCIATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM JAY SKYLER, PROFESSOR AND CO-DIRECTOR OF THE BEHAVIORAL MEDICINE RESEARCH CENTER AT THE UNIVERSITY OF MIAMI AND PRESIDENT-ELECT OF THE AMERICAN DIABETES ASSOCIATION.

I AM HERE ON BEHALF OF THE ADA, THE NATION'S LARGEST VOLUNTARY HEALTH AGENCY SERVING THE HEALTH-CARE AND MEDICAL RESEARCH INTERESTS OF OVER 14 MILLION PEOPLE WITH DIABETES. ADA IS COMPRISED OF 54 STATE AFFILIATE ASSOCIATIONS, 800 LOCAL CHAPTERS AND OVER 280,000 LAY AND PROFESSIONAL MEMBERS.

DIABETES IS A MAJOR PUBLIC HEALTH PROBLEM. HEALTH CARE AND RELATED COSTS FOR DIABETES TREATMENT RUN OVER $20.4 BILLION ANNUALLY AND ACCOUNT FOR NEARLY 5 PERCENT OF TOTAL U.S. HEALTH-CARE COSTS.

THE ECONOMIC BURDEN RESULTING FROM A CHRONIC ILLNESS SUCH AS DIABETES IS OF MAJOR IMPORTANCE IN THE ALLOCATION OF HEALTH-CARE RESOURCES AND IN THE EVALUATION OF HEALTH RESEARCH AND TREATMENT PROGRAMS. IN LIGHT OF TODAY'S SPIRALING HEALTH-CARE COSTS, WE MUST DEVELOP COST-EFFECTIVE WAYS OF PRESERVING AND ENSURING OUR NATION'S HEALTH.

ACHIEVING THIS OBJECTIVE REQUIRES A NEW APPROACH TO SOME VERY OLD PROBLEMS AND I COMMEND THIS SUBCOMMITTEE FOR RECOGNIZING THE IMPORTANCE OF PREVENTION AS A MEANS TO THAT END. AS A PHYSICIAN WHO ROUTINELY ESPOUSES THE VIRTUES OF EARLY INTERVENTION, I AM HAPPY TO SAY THAT PREVENTION IS A GOOD IDEA WHOSE TIME HAS COME. THIS IS ESPECIALLY TRUE FOR PEOPLE WITH DIABETES.

AS I MENTIONED, DIABETES AFFECTS MORE THAN 14 MILLION AMERICANS. IT IS A MAJOR CAUSE OF HOSPITALIZATION, DISABILITY AND SUFFERING AND, WITH ITS COMPLICATIONS, IS THE THIRD LEADING CAUSE OF DEATH FROM DISEASE IN THE UNITED STATES.

THE TABLE BELOW SUMMARIZES THE SOBERING MORBIDITY AND MORTALITY ASSOCIATED WITH DIABETES.

- DEATHS. EACH YEAR, ABOUT 250,000 PEOPLE DIE AS A RESULT OF DIABETES AND ITS COMPLICATIONS.

- AMPUTATIONS. APPROXIMATELY 45 PERCENT OF ALL NON-TRAUMATIC LEG AND FOOT AMPUTATIONS IN THE U.S. ARE CAUSED BY DIABETES.

- BLINDNESS. EACH YEAR, 12,000 PEOPLE LOSE THEIR SIGHT BECAUSE OF DIABETES. IT IS THE NUMBER ONE CAUSE OF NEW BLINDNESS IN PEOPLE BETWEEN THE AGES OF 20-74.

- HEART DISEASE AND STROKE. PEOPLE WITH DIABETES ARE 2 TO 4 TIMES MORE LIKELY TO HAVE HEART DISEASE AND 2 TO 6 TIMES MORE LIKELY TO HAVE A STROKE THAN PEOPLE WHO DO NOT HAVE DIABETES.

- MINORITIES. TWENTY PERCENT OF ALL PEOPLE WITH DIABETES ARE EITHER BLACK OR HISPANIC. THE RATE OF NON-INSULIN-DEPENDENT DIABETES IS 33 PERCENT HIGHER IN BLACKS AND 300 PERCENT HIGHER IN HISPANICS THAN IN WHITES. OVER 50 PERCENT OF THE ADULTS IN SOME NATIVE AMERICAN TRIBES HAVE DIABETES.

THE PERSONAL AND ECONOMIC COSTS OF DIABETES RESULT BOTH FROM ACUTE COMPLICATIONS SUCH AS POOR DIABETES CONTROL (HIGH AND LOW BLOOD SUGARS), AND LONG-TERM COMPLICATIONS SUCH AS VASCULAR DISEASES CAUSING STROKE, HEART DISEASE AND AMPUTATIONS; EYE DISEASE CAUSING SEVERE VISUAL LOSS AND BLINDNESS; KIDNEY DISEASE REQUIRING DIALYSIS OR KIDNEY TRANSPLANTATION; AND IMPOTENCE.

THE COMPLICATIONS OF DIABETES AND PREMATURE MORTALITY ARE NOT INEVITABLE. MODERN THERAPIES CAN REDUCE HOSPITALIZATIONS FOR UNCONTROLLED DIABETES.

LIKEWISE, EARLY INTERVENTION AND BETTER MANAGEMENT CAN RETARD THE DEVELOPMENT OF LONG-TERM COMPLICATIONS. FOR EXAMPLE, STUDIES HAVE SHOWN THAT CERTAIN INDIVIDUALS MAY PREVENT OR DELAY DIABETIC FOOT PROBLEMS BY WEARING SPECIALLY DESIGNED THERAPEUTIC SHOES.

CURRENTLY, ABOUT 45 PERCENT (OR MORE THAN 30,000) OF ALL NON-TRAUMATIC LEG AND FOOT AMPUTATIONS IN THE U.S. ARE CAUSED BY DIABETES. BECAUSE PEOPLE WITH DIABETES FACE AN INCREASED RISK OF AMPUTATION OF THE TOE, FOOT, OR LOWER LEG, EARLY DIAGNOSIS AND TREATMENT OF FOOT PROBLEMS IS CRITICAL. ONE WAY OF MINIMIZING SUCH RISKS IS TO USE THERAPEUTIC SHOES.

THERAPEUTIC SHOES ARE PRESCRIBED BY A PHYSICIAN AND ARE FITTED OR MOLDED TO A PERSON'S FEET. SIMPLY STATED, THE SHOES ARE DESIGNED TO PROMOTE THE HEALING OF INJURIES, ULCERS AND OTHER FOOT DEFORMITIES THAT, WITHOUT THESE SHOES, CAN LEAD TO AMPUTATION.

IN 1987, CONGRESS RECOGNIZED THE IMPORTANCE OF PREVENTION STRATEGIES WHEN IT MANDATED THAT MEDICARE CONDUCT A DEMONSTRATION PROJECT TO DETERMINE WHETHER THERAPEUTIC SHOES FOR MEDICARE BENEFICIARIES WITH DIABETES ARE COST-EFFECTIVE.

TO BE ELIGIBLE FOR THE MEDICARE BENEFIT AT THIS TIME, AN INDIVIDUAL MUST LIVE IN CALIFORNIA, FLORIDA OR NEW YORK; HAVE MEDICARE PART B COVERAGE; HAVE DIABETES AND FOOT DISEASE; AND NOT BE ENROLLED IN A MEDICARE HMO.

THE DEMONSTRATION PROJECT IS BEING CONDUCTED BY MATHMATICA POLICY RESEARCH INC. AND, TO DATE, OVER 3,000 VOLUNTEERS HAVE BEEN REGISTERED. HALF OF THESE VOLUNTEERS WILL BE REIMBURSED BY MEDICARE FOR 80 PERCENT OF THE COST OF THE SHOES.

THE INTENT OF THE PROJECT IS TO SHOW THE COST-EFFECTIVENESS OF PROVIDING THERAPEUTIC SHOES FOR A MEDICARE BENEFICIARY WITH DIABETIC FOOT DISEASE.

THE THERAPEUTIC SHOE DEMONSTRATION PROJECT IS JUST ONE EXAMPLE OF THE MANY OPPORTUNITIES WHICH EXIST FOR EARLY INTERVENTION AND, ULTIMATELY, PREVENTION OF DIABETES AND ITS COMPLICATIONS. ANOTHER CRITICAL FACTOR IN PREVENTING ACUTE AND LONG-TERM COMPLICATIONS, AS WELL AS DAY-TO-DAY CONTROL OF THE DISEASE, IS SELF-MANAGEMENT. PEOPLE WITH DIABETES MUST UNDERSTAND THEIR DISEASE AND KNOW HOW TO PERFORM OPTIMAL SELF-CARE AND OUTPATIENT EDUCATION IS THE KEY TO BETTER MANAGEMENT.

OUTPATIENT EDUCATION IS NOW ACCEPTED AS AN INTEGRAL PART OF DIABETES CARE. SUCH EDUCATION, BEST PROVIDED BY A MULTIDISCIPLINARY HEALTH-CARE TEAM, ENABLES PATIENT ADHERENCE TO THE COMPLICATED AND TIME-CONSUMING DIABETES TREATMENT REGIMEN. EFFECTIVE SELF-MANAGEMENT INVOLVES COORDINATION OF A CONSISTENT MEAL PLAN, REGULAR EXERCISE AND ORAL MEDICATION OR INJECTED INSULIN. FREQUENT SELF-MONITORING OF BLOOD GLUCOSE PROVIDES IMMEDIATE INFORMATION TO THE PATIENT ENABLING APPROPRIATE ADJUSTMENTS TO BE MADE IN THE MEDICATION, DIET OR EXERCISE.

NUMEROUS PUBLISHED STUDIES HAVE SHOWN THAT EDUCATION PROGRAMS FOCUSED ON PATIENT SELF-CARE CAN LEAD TO REDUCTIONS IN THE COSTS ASSOCIATED WITH DIABETES MANAGEMENT. FOR EXAMPLE, KNOWLEDGEABLE PATIENTS ARE ABLE TO START INSULIN IN AN OUTPATIENT SETTING AND AVOID COSTLY HOSPITALIZATION. KNOWLEDGE OF APPROPRIATE SELF-CARE AND ACCESS TO MEDICAL ADVICE VIA THE PHONE CAN REDUCE THE USE OF HOSPITAL EMERGENCY SERVICES FOR ACUTE COMPLICATIONS INVOLVING HIGH OR LOW BLOOD GLUCOSE LEVELS. THE INITIATION OF A PRECONCEPTION CARE PROGRAM FOR WOMEN WITH DIABETES WHO ARE OF CHILDBEARING AGE CAN RESULT IN SIGNIFICANT DIRECT MEDICAL COST SAVINGS BY AVOIDING ADVERSE FETAL AND MATERNAL OUTCOMES.

ALTHOUGH THE LINK BETWEEN EDUCATION AND THE PREVENTION OF CHRONIC COMPLICATIONS IS MORE TENUOUS, CARE PROVIDERS WOULD BE NEGLIGENT IF, FOR EXAMPLE, PATIENTS WERE KEPT UNAWARE OF THE NEED FOR ANNUAL EYE EXAMS OR DAILY FOOT CARE. SINCE THE ACUTE CARE HOSPITAL CAN ONLY MEET ACUTE EDUCATION NEEDS, ONGOING ESSENTIAL EDUCATION SERVICES ARE MOST EFFECTIVELY AND EFFICIENTLY PROVIDED IN AN OUTPATIENT SETTING.

THE AMERICAN DIABETES ASSOCIATION HAS ASSUMED A LEADERSHIP ROLE IN THE DIABETES COMMUNITY BY DEVELOPING POSITION STATEMENTS REGARDING HOSPITAL ADMISSION GUIDELINES FOR DIABETES MELLITUS, AND THIRD-PARTY REIMBURSEMENT FOR OUTPATIENT DIABETES EDUCATION AND COUNSELING. STANDARDS FOR MEDICAL CARE AND DIABETES PATIENT EDUCATION AS WELL AS GUIDELINES FOR EYE AND FOOT CARE ARE WIDELY DISSEMINATED. A NATIONWIDE QUALITY ASSURANCE PROCESS FOR DIABETES PATIENT EDUCATION PROGRAMS HAS ALSO RECENTLY BEEN ESTABLISHED.

ALTHOUGH PREVENTION AND EARLY INTERVENTION CLEARLY HAVE A SIGNIFICANT POSITIVE IMPACT ON COSTS AND QUALITY OF LIFE, THE HEALTH-CARE DELIVERY SYSTEM IS CURRENTLY RELUCTANT TO SUPPORT THE PROVISION OF THESE SERVICES. A NATIONAL CONFERENCE HELD TO ADDRESS THE FINANCING OF DIABETES CARE IN THE 1990s IDENTIFIED SEVERAL KEY ISSUES. A MAJOR CONCERN IS THE LACK OF FIT BETWEEN THE NEEDS OF PEOPLE WITH DIABETES AND THE MEANS OF PROVIDING AND REIMBURSING SERVICES UNDER THE PREVAILING ACUTE DISEASE OR "MEDICAL" MODEL. A BETTER MODEL FOR DIABETES AND OTHER CHRONIC DISEASES WOULD ENCOURAGE THE PROVISION OF PREVENTIVE SERVICES, SUCH AS OUTPATIENT EDUCATION, AND REIMBURSEMENT OF NON-PHYSICIAN HEALTH PROFESSIONAL SERVICES. CURRENTLY, ALTHOUGH MEDICARE HAS CLEAR GUIDELINES FOR INTERMEDIARIES TO REIMBURSE ESSENTIAL OUTPATIENT EDUCATION SERVICES AFFILIATED WITH A HOSPITAL OR RURAL HEALTH CLINIC THAT ARE ORDERED BY A PHYSICIAN, SUCH COVERAGE IS INCONSISTENT AND UNPREDICTABLE. EDUCATION SERVICES PROVIDED IN A PHYSICIAN PRACTICE ARE NOT COVERED BY MEDICARE AT ALL.

THE PROVISION OF THERAPEUTIC SHOES AND OUTPATIENT DIABETES EDUCATION ARE JUST TWO EXAMPLES OF MEDICAL CARE THAT ARE FREQUENTLY DESCRIBED AS "PREVENTIVE" SERVICES. THE DIFFERENCE BETWEEN PREVENTION AND TREATMENT MAY BE CONFUSING. OUR EXPERIENCE INDICATES THAT THEY ARE OFTEN THE SAME. FOR EXAMPLE, SHOES ARE MEDICALLY NECESSARY TREATMENT FOR FOOT ULCERS, BUT ALSO HELP PREVENT UNNECESSARY AMPUTATIONS. WE WANT TO ENCOURAGE YOUR SUBCOMMITTEE TO LOOK BEYOND THE WORDS AND INSTEAD, FOCUS ON ESSENTIAL AND APPROPRIATE MEDICAL CARE.

WE APPLAUD THE INTRODUCTION OF H.R. 2565 IN RECOGNIZING THE IMPORTANCE OF REIMBURSEMENT FOR SCREENING AND IMMUNIZATION SERVICES. HOWEVER, THIS PIECE OF LEGISLATION DOES NOT GO FAR ENOUGH; IT DOES NOT ADDRESS THE BENEFITS, IN HUMAN AND ECONOMIC TERMS, OF REIMBURSEMENT FOR PREVENTIVE CARE. ON BEHALF OF THE AMERICAN DIABETES ASSOCIATION, I URGE THE MEMBERS OF THIS SUBCOMMITTEE TO INCLUDE IN THIS BILL SERVICES FOR CHRONICALLY ILL INDIVIDUALS, SUCH AS THOSE WITH DIABETES.

THANK YOU FOR YOUR TIME AND THE OPPORTUNITY TO SPEAK ON SUCH AN IMPORTANT ISSUE.

Chairman STARK. Is diabetes detected during screening? Do you always catch it or is it a much more complex series of tests that is needed?

Dr. SKYLER. It is not really a problem. It is accomplished so cheaply and easily. One can do a blood test; one can select the population to do it in. We believe the blood test ought to be done in the context of an overall general exam, and paying attention particularly to the populations that are highest at risk.

But the test is a cheap, inexpensive one and is generally accomplished already through the system that is in place. So we are not advocating any additional things for diagnosing diabetes per se.

Chairman STARK. They haven't found that the standard test is not sufficient?

Dr. SKYLER. It is generally sufficient as a screening test, but folks who fail the screening need to go on to a diagnostic test, just like anyone else.

More of an issue is the one that was raised previously. We need to get folks to have access to the system more, because we estimate that for every patient in the United States who has diabetes, there is one who has it and doesn't know it. So that the—and that comes from the Hanes survey and the like that have really gone in and identified folks——

Chairman STARK. I appreciate your lack of parochialism, but I was particularly curious about that in this case. And saving one of the most important for last, we will now hear from the American Association of Retired People. Anne Jackson, please proceed in any manner you feel comfortable.

STATEMENT OF ANNE JACKSON, MINORITY AFFAIRS SPOKESPERSON, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. JACKSON. Good afternoon. Thank you for having me here. I am Anne Jackson from Queens, NY. I am a minority affairs spokesperson for the American Association of Retired Persons.

AARP commends Chairman Rostenkowski and you, Chairman Stark, as well as other members of the committee for introducing the Medicare Preventive Services Benefits Act of 1991.

My testimony focuses on three areas: First, the effect of rising health care costs on the ability to obtain preventive care; second, the importance of the benefits included in H.R. 2565; and, third, financing the benefits.

To fully understand how important Medicare coverage of preventive care is, we only have to look at how rising health care costs have widened the gaps in Medicare's protection. When it was created in 1965, Medicare dramatically increased access to health care services and reduced out-of-pocket medical expenses for beneficiaries. But over the years, as health care costs have increased, this protection has diminished. Beneficiary premiums and coinsurance have risen steadily. Out-of-pocket expenses for noncovered services such as prescription drugs and preventive care have also increased. It is estimated that for every dollar beneficiaries spend on Medicare-covered services, they spend another 50 cents to a dollar on noncovered services. The rise in health care costs has had such an impact that the older person now spends about 15 percent of their

income on health care. This is roughly the same amount that they spent before Medicare was enacted.

Coverage of preventive care would do several things to improve the situation. It would close more gaps in Medicare's protection. It would make preventive services more affordable. And also, it would help avoid greater costs that occur when the early warning system of preventive care is not available.

H.R. 2565 takes major steps in this direction by expanding Medicare to include coverage of annual mammograms, cholorectal cancer screening, flu vaccines, and well-child care for Medicare-eligible children with end-stage renal disease. All these services will enable beneficiaries to better safeguard their health.

We are pleased to note that H.R. 2565 also establishes demonstration projects which could lead the way toward Medicare coverage of additional preventive benefits, including comprehensive health assessments for older beneficiaries, which AARP views as a foundation for maintaining good health.

H.R. 2565 proposes no method for financing these new and expanded benefits. Considering the current budget rules, the lack of a financing mechanism does raise some concerns.

Given the road that you and we have traveled over the last years—a beneficiary-only financing method is not what AARP would want to see used for benefit expansion. We view the traditional financing of Medicare part B, which spreads the program's costs across the entire population, as a fundamental tenet of Medicare, which should not be breached lightly.

In conclusion, let me say that AARP applauds your efforts to establish coverage for preventative care benefits. It is an important step toward broadening access to health care. We continue to believe, however, that the only way to really assure access to all people and control the rising costs of health care is through comprehensive health care reform.

AARP has no illusions about a quick solution, but we believe that by garnering broad public consensus on the risk of continuing a piecemeal approach to health care, we can achieve comprehensive reform. To this end, AARP will continue our public education efforts, and we urge the Congress to lay the groundwork that will focus public attention on the tough choices that must be made as part of the solution.

Clearly, the 1992 elections offer the most important opportunity to help solidify America's commitment to this goal. AARP and thousands of our volunteer leaders stand ready to help make these elections a focal point in the national debate over health care reform.

Mr. Chairman, thank you for the opportunity to have me here. AARP looks forward to working with you and with other members of this committee on health care issues.

Chairman STARK. Thank you, Ms. Jackson.

[The prepared statement follows:]

TESTIMONY OF ANNE JACKSON
AMERICAN ASSOCIATION OF RETIRED PERSONS

Good afternoon. My name is Anne Jackson. I am from Queens, New York. I am a Minority Affairs Spokesperson for the American Association of Retired Persons. I am pleased to have the opportunity today to discuss the continuing need for Medicare coverage of preventive health care services. AARP commends Chairman Rostenkowski, and you Chairman Stark, as well as other members of this committee for introducing the Medicare Preventive Services Benefits Act of 1991.

It is often said that an ounce of prevention is worth a pound of cure. Early detection of a potentially serious illness not only saves the expense of costly treatments later--it often saves lives. Yet millions of Americans have no coverage for even the most basic preventive care. Over the past few years some improvements have been made in Medicare's coverage of preventive services--specifically coverage for hepatitis B vaccines, biennial mammography screening and pap smears. But significant gaps still remain.

My testimony today will focus on three areas: 1) the effect of rising health care costs on older Americans' ability to obtain needed preventive care; 2) the importance of the four benefits included in H.R. 2565: annual mammography screening, colorectal cancer screening, flu vaccines and well-child care for ESRD program participants under the age of 7; and 3) financing the new and expanded benefits.

Rising Health Care Costs

To fully understand how important Medicare coverage of preventive care is, it is necessary to look at how increasing health care costs have widened the gaps in Medicare's protection of older beneficiaries.

Medicare is the cornerstone of health care coverage for older and disabled Americans. Approximately 30 million older persons and over 3 million disabled persons are covered by Medicare Part A (hospital insurance). Over 29 million elderly and 3 million disabled pay the monthly premium for Part B (physician services) covered services.

When it was created in 1965, Medicare dramatically increased access to acute health care services and reduced out-of-pocket medical expenses for most older persons. But over the years, the gaps in Medicare's protection have gradually widened. It is estimated that older Americans now spend 15 percent of their yearly income on health care--roughly the same percentage they spent before Medicare was enacted.

Rising health care costs are the primary reason. In 1989, health care expenditures in the U.S. totalled $604.1 billion, an increase of over 11 percent from the previous year. Expenditures for physician services increased nearly 12 percent to $117 billion and hospital spending increased by 10 percent. Americans paid nearly $125 billion out-of-pocket for health care--over 23 percent of total health care spending. Unfortunately, these expenditures are not anomalies, but are part of a disturbing yearly trend of double digit increases in health care spending.

These cost increases have an even greater impact on Medicare beneficiaries. Over the past few years, beneficiaries have experienced steady increases in premiums and coinsurance, and last year the Medicare Part B deductible was raised to $100. Higher health care costs also translate into higher out-of-pocket expenses for non-covered services, such as prescription drugs, long-term care and preventive care. It is estimated that for every dollar beneficiaries spend on Medicare covered services, they spend another fifty cents to one dollar on these non-covered services. For example, in 1989 alone, beneficiaries spent $2 billion on physician balance billing charges. Long-term care

charges account for 81% of the annual out-of-pocket expenses over $2,000 incurred by elderly persons. In many cases, these escalating costs have created insurmountable financial barriers to important medical care.

The expansion of Medicare to include preventive services is a significant step toward closing the gaps in Medicare's protection of the elderly and is particularly important for those low-income beneficiaries who could not afford this type of coverage any other way.

Annual Mammography Screening

Breast cancer is the second leading cause of cancer deaths among women today. In 1989 alone, nearly 150,000 women--90 percent of them over the age of 50--developed breast cancer. Over 40,000 of these women died. Tragically, a third of these deaths could have been prevented by early detection.

This year, one in nine women in America will develop breast cancer and older women are the most vulnerable. While there is still a lack of comprehensive age-specific research on the appropriate frequency of mammography screening for older women, what is known is that older women are nearly twice as likely to develop breast cancer as younger women. In light of this, the American Cancer Society and the National Cancer Institute recommend annual mammograms for women over the age of 50.

The current Medicare mammography benefit provides only biennial coverage for women over the age of 64. H.R. 2565 would allow all Medicare beneficiaries over the age of 50 to receive annual mammography screening.

Colorectal Cancer Screening

Each year, over 100,000 people 65 years of age and older are diagnosed with colorectal cancer. In fact, nearly three out of every four new cases of colorectal cancer occur in people 65 years of age or older. As a person ages, the risk of colorectal cancer increases. According to the Office of Technology Assessment, the incidence of colorectal cancer in men 50 years of age is 57 per 100,000. By the age of 65, the incidence rises to 244 in 100,000 and by 75 years old it is 411 cases per 100,000. While women have lower rates of colorectal cancer, the incidence still increases with age.

When colorectal cancer is detected at an early stage, the rate of recovery is very encouraging--80 percent for colon cancer and 88 percent for rectal cancer. Yet the two most common tests for detection of this disease--a stool blood slide and proctosigmoidoscopy--are not covered by Medicare.

H.R. 2565 follows the frequency guidelines of the American Cancer Society and would provide Medicare coverage of annual fecal occult blood tests and screening sigmoidoscopies every five years. Colorectal cancer is the third leading cause of cancer deaths in both men and women. Coverage of these two important preventive tests will enable thousands of Medicare beneficiaries to safeguard their health.

Flu Vaccines

For many Americans, an onset of the flu is not a serious condition. But for some, particularly older persons, influenza is often life-threatening. Over the last 20 years, an estimated half million Americans have died as a result of flu epidemics.

Both the Centers for Disease Control and the American College of Physicians recommend flu vaccines for persons over the age of 65, yet Medicare does not cover this service for all beneficiaries.

Congress recognized the importance of making flu vaccines available to older Americans when it approved a vaccine demonstration project as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987. If the vaccine is determined to be cost-effective, the law provided that Medicare would be expanded to include coverage of the benefit. Unfortunately, the initial report on the project, which was due in October, 1990, has still not been released and Medicare coverage of flu vaccines remains limited in scope. Since it is not clear when the report's findings will be available, only a small number of beneficiaries enjoy this protection. H.R. 2565 would provide Medicare coverage of flu vaccines nationwide, thereby ensuring that all beneficiaries are protected from a potentially serious condition.

Well-Child Care for ESRD Beneficiaries

The Medicare program currently provides coverage for qualified children with End Stage Renal Disease. These children are eligible for all Part A benefits, including transplants, as well as Part B services. Yet Medicare's lack of preventive coverage means that these children can receive care for renal failure, but not for the basic preventive care necessary to ensure their overall good health.

H.R. 2565 would remedy this problem for approximately 500 children under the age of seven. In addition to their current Medicare benefits, ESRD children would also be covered for routine immunizations, office visits and lab tests.

Including coverage of preventive services for these children is a logical step. Medicare already covers the services associated with end stage renal disease, yet without good basic care, many of these other services are not as effective as they could be. This improvement in Medicare will ensure that a particularly vulnerable population of beneficiaries has access to the care they most need.

Preventive Care Demonstration Projects

H.R. 2565 establishes a series of preventive care demonstration projects to examine the feasibility of expanding Medicare coverage for additional preventive care services. We are very pleased that one of the demonstration projects included in this provision is a one-time comprehensive health assessment for older individuals. General physical examinations, the foundation for maintaining good health, are not covered by Medicare. This means that many older persons often do not seek care until symptoms of an illness exist. By that time their health may well be in danger and the risk of higher health care costs is greater. AARP believes that health assessment should be part of any comprehensive preventive health care program.

OTA Study

AARP is also pleased that H.R. 2565 requires the Office of Technology Assessment, after conducting a study, to recommend a process for determining the criteria to be used in making coverage decisions for additional preventive services.

AARP believes that this type of study is needed. While the Association supports coverage of preventive care under Medicare, we believe that tests of appropriateness and effectiveness must be applied to coverage of preventive services just as they should be applied to the rest of the health care system. Preventive screening techniques should not be used simply because they are available but because they are effective means of detecting and preventing illness.

Financing

H.R. 2565 proposes no specific method for financing the new and expanded preventive benefits. Given the current budget rules, the lack of a financing mechanism raises some concerns.

It should come as no surprise that, given the road that you and we have travelled over the last several years, a beneficiary-only financing method is not what AARP would want to see used for future benefit expansions. The Association views the traditional financing of Medicare Part B--which spreads the cost of the program across the entire population--as a fundamental tenet of the Medicare program which should not be breached lightly.

In this regard, I would like to dispel the erroneous claim that since Medicare beneficiaries only pay 25% of program costs and 75% is subsidized through general tax revenues, upper income beneficiaries receive undue benefits at the expense of general taxpayers. All Medicare beneficiaries, despite their income, pay approximately 25% of program costs through premiums, but what is often ignored is the fact that over half of the over 30 million beneficiaries also pay federal income tax which helps to subsidize the Part B Trust Fund. In short, Medicare beneficiaries who are more fortunate than others help support those who are less fortunate.

Conclusion

AARP applauds your efforts to establish Medicare coverage for some very important preventive care benefits. Closing more gaps in Medicare's coverage by including preventive care benefits is an important step towards broadening access to health care. But only through comprehensive reform of our health care system will we bring health care costs under control and guarantee individuals of all ages access to care.

We recognize that the key to achieving the goal of comprehensive reform is through a broad public consensus about the problems and the risks of inactivity. AARP has made great progress in educating its members to develop a better understanding of this crisis and find realistic solutions. However, we cannot do this alone. It is incumbent upon the Administration and a bi-partisan Congress, as well as AARP and other groups, to lay the groundwork that will focus public attention on the tough choices that must be part of the solution, including the questions:

- o What elements of a health care system are most important to Americans?

- o Are we willing to make the trade-offs that will be necessary to ensure access for all Americans?

- o Are we willing to pay the cost of these benefits, not only in the aggregate, but as individual taxpayers?

Taken together, these are the focal points in the debate over health care reform. AARP believes that any financing of health care reform should be broad-based and equitable. Social insurance programs, like Social Security and Medicare, enjoy considerable public support. Comprehensive health care reform will only achieve broad support if it is primarily financed through a social insurance structure.

We have no illusions about a quick solution to problems facing our health care system, but clearly, the 1992 elections will offer an important opportunity to help solidify America's commitment to reforming our health care system. AARP and thousands of our volunteer leaders stand ready to ensure that the 1992 elections will be a focal point in the national debate over health care reform.

Mr. Chairman, thank you for the opportunity to testify today. AARP looks forward to working with you on this and other health care legislation in the future.

Chairman STARK. Do you work full time on AARP projects or do you have another profession or vocation?

Ms. JACKSON. I am a volunteer for AARP, and some other programs.

Chairman STARK. What do you do in between times?

Ms. JACKSON. I read. I cycle.

Chairman STARK. Do you live in Queens?

Ms. JACKSON. Yes.

Chairman STARK. You belong to a professional women's club or a church group or some large group other than AARP?

Ms. JACKSON. Yes, I belong to church groups.

Chairman STARK. How many women would you guess in your church are Medicare beneficiaries—50, 100?

Ms. JACKSON. The church is a small church. We have about a 200-person membership. I would think about half of them should be considered to be Medicare beneficiaries.

Chairman STARK. Out of that maybe 50 women in your church would qualify for Medicare——

Ms. JACKSON. Yes, I would think so; maybe a little more.

Chairman STARK. How many would you guess have had a mammogram screening?

Ms. JACKSON. I don't really know.

Chairman STARK. If I said, "OK, I will give you $50 per person towards the organ fund or something," how would you go and organize? What would you do to encourage them. Would you give them a free bingo card, a free night at the races, or a trip to Disneyland?

What would you do to say, "Come on. We are all going to go down and get a bus."

Ms. JACKSON. I think what I would do is go to the group and say to them, are you really aware of the effects of a mammogram or haven't you had one?

Chairman STARK. Would you try and scare them, saying, "Here are the effects if you don't"?

Ms. JACKSON. Yes, I would tell them what the effects are, but I also think that women in my era and some of those that are just above me are a little reluctant about having personal exams such as mammograms so as a result I would then have to go into detail and explain to them that this is not—the word escapes me right now——

Chairman STARK. Invasive?

Ms. JACKSON. Yes, that it is not an invasive procedure. Also, that there are no detrimental effects from having had a mammogram. There are people out there who think if you have so many mammograms, that x ray tends to predispose you to the development of cancer, which they are all afraid of.

Chairman STARK. Do you think that if they are Medicare beneficiaries, that their perception would be that Medicare plus their good AARP medigap policy would take care of the cost? Would their perception be that, since I am a Medicare beneficiary I will have the screening, or would I say, well, you know, Ms. Jackson, how much does that cost?

Ms. JACKSON. I think that one of our roles would be to teach beneficiaries to be concerned about the cost of anything, just as when they go to the grocery store they check the costs. On the

other hand, I would think they need to know that even though it would cost them $55, that the benefits are worth $55.

Chairman STARK. It wouldn't cost them that, would it? It might cost them $20, I am just guessing, but it depends on the cost and inconvenience. I don't mean to belittle the idea, but you have somebody who says, "This is going to hurt, or certainly be uncomfortable, I am not going to like it. I would rather go to the movies or watch television," then you are going to tell them it is going to cost $20, or whatever their share of the copay will be if they don't have medigap insurance. It is not like saying let's go to the flower show, if you have a free ticket.

So I don't know, and I don't know what—I will just ask Dr. Steinwachs, what did you find? As it turns out you were the thesis adviser of Mr. Reuter on our staff, and he is dying to have a chance to examine you, but I held him back.

Mr. STEINWACHS. I am happy you were able to restrain him.

One thing we were concerned about, and I would be happy to share this with you, but the word "prevention" I am not sure what it means to many people and the older group, but we developed an idea called Senior Health Watch, and we called it working with your doctor for better health.

We think the need to use terminology that is sometimes a little different——

Chairman STARK. Not only this, but a number of things. I have thousands of people in my district who qualify for SSI and don't get it.

You know, in California, our SSI payment was $650. We supplement about $400. It is still a lot, and with a lot of people with a $200 to $300 Social Security check as their only income, why can't we find these people?

Ms. JACKSON. I do think that education is a big problem. We can publish material but many of the people who really need the services, if they read the material, if they are able to read the material, may not always comprehend.

Chairman STARK. That may be a question of poverty. In my area, it may be a question of ethnic origin. They may speak a different language or read hesitatingly in English.

Mr. STEINWACHS. If I may, it seems to me, though, when you define part of Medicare's role as an outreach role, if we can do that, as you know, Medicare knows where those individuals live, and I have the impression that——

Chairman STARK. Oh, I could do it, but Mr. Sununu wouldn't let me run the Medicare program.

Mr. STEINWACHS. I have the impression that Gail Wilensky was interested in part of this, too.

I don't know where that is going. I don't know much about it currently, but it would be wonderful if we could define part of the mandate of the program as an outreach and education. I recognize that is not easy.

Chairman STARK. Let me take the last question, then, and that is to ask both of you from the standpoint of how you think people would react and how much we could insist on, but this idea of an entry exam for Medicare. The worst of all worlds is that people would turn it down, which is absolutely to their disadvantage, be-

cause it is arguably such a unique program without which no one should enter into their golden years.

Could we do that? Could you say, how you have to go down and have an interview, you have got to soft sell it, I think.

How would you sell that one to your parishioners?

Ms. JACKSON. I would say for those who are my peers and older, it might be a difficult sale, but for those who are younger, I could use my background as a nurse to say, "I have been in the health field and I know what the benefits of prevention are." I think you could sell it.

Chairman STARK. If I may, and I apologize for not being as familiar as I should, but the sickle cell issue is one of younger black people——

Ms. JACKSON. Older, too.

Chairman STARK [continuing]. But who wants to become parents. Is there some—is that sold through fear? You better get this test?

Ms. JACKSON. No, I can't say that it is. Nobody says that you have to do it. The only thing that you can do is point out to them that you should.

Chairman STARK. Do we have very good participation in that kind of screening?

Ms. JACKSON. Unfortunately, I can't say. I don't know.

Chairman STARK. Maybe you know, Dr. Steinwachs.

Mr. STEINWACHS. I think one thing the demonstration programs you have now pointed to in Baltimore, you have two-thirds of the individuals out over a 2-year period, and that is with a letter and explanation, a brochure, not a lot of effort.

This isn't aggressively pursuing—and across both education and income, so it seems to me if you have that upfront as a requirement where you go to your physician and do this, then I think you would find a high degree of acceptability.

Chairman STARK. The AARP, how many members do you have?

Ms. JACKSON. 33 million.

Chairman STARK. What if we got AARP a discount to everybody who goes to have the screening?

Ms. JACKSON. It might be a thought, who knows?

Chairman STARK. You can bring it up to the board.

I want to thank both of you witnesses for your patience, your charm, and your help on this project. I hope we will be able to do something, and once we enact the legislation. That is the easiest part of our job. Then we must make sure the outreach program works and people participate, so the benefit has the effect I am sure we know it will.

Thank you very much.

The meeting is adjourned.

[Whereupon, at 4 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN CANCER SOCIETY®
NATIONAL PUBLIC AFFAIRS OFFICE

July 2, 1991

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the American Cancer Society, I would like to submit written comments on colorectal cancer for the record of your June 20, 1991 hearing.

Currently, about 157,500 new cases of colorectal cancer are diagnosed each year; about 60,500 people will die from the disease in 1991. The incidence of colorectal cancer tends to increase with age, starting at 40 years. More than 94% of all cases occur after the age of 50. Colorectal cancer occurs about equally in both sexes. Anyone with a personal or family history of colorectal cancer, polyps in the colon, or inflammatory bowel disease is at particularly high risk for the disease and should be examined carefully. Evidence suggests that bowel cancer may be linked to a diet high in fat and/or low in fiber content.

Because colorectal cancer develops over a period of time, detection of the disease is possible long before symptoms appear. Early detection of small cancers and polyps reduces the likelihood of major surgery and the need for a colostomy (an abdominal opening created for the elimination of wastes). In fact, permanent colostomies are rare in cases of colon cancer, and are necessary in only 15% of rectal cancer cases.

When cancer of the colon and rectum is found and treated in any early, localized state, the 5-year survival rate is 99% for colon cancer and 80% for rectal cancer. However, survival figures drop to 58% and 47%, respectively, after the cancer has started to spread regionally.

AMERICAN CANCER SOCIETY, INC.
316 PENNSYLVANIA AVE., S.E., SUITE 200, WASHINGTON, D.C. 20003 202-546-4011

With early detection techniques, such as the digital rectal exam, the stool blood test, and sigmoidoscopy, and with appropriate management, about 50,000 more of those diagnosed this year could be saved.

It is recommended that the following procedures, all part of a cancer-related checkup, be performed at designated intervals:

- A digital rectal examination every year after age 40.
- A stool blood test every year after age 50.
- A sigmoidoscopy every three to five years after the age of 50.

These guidelines apply only to people without symptoms. Persons with rectal bleeding, cramping abdominal pain, or a change in bowel habits should see their physicians immediately.

A 1987 study of men and women age 40 and over, conducted for the Society by the Gallup Organization, revealed a number of important findings concerning Americans' attitudes toward detection measures for colorectal cancer. There has been some increase in public awareness of the 3 tests recommended to detect the disease, but there is much room for improvement. The study found, for instance, that the percentage of Americans who ever had a digital rectal examination increased slightly since 1983, from 51% to 56%. Likewise, the percentage of Americans who ever had a stool blood test rose, from 28% in 1983 to 40% in 1987. And while the percentage of men and women 50 and over who ever had a proctoscopic examination rose from 31% in 1983 to 42% in 1987, 60% of Americans who should have had the examination (according to Society guidelines) had not had it.

The survey also showed that 25% of those individuals in the 40-plus age group have ever asked their doctor to examine their colon or rectum. And of this group, more than half did so only because something was bothering them.

On the promising side, the survey showed that almost 50% of all Americans would be interested in learning more about this form of cancer.

Thank you. If you have any questions or concerns, please contact Kerrie Wilson or Nancy Hailpern of our Washington staff at (202) 546-4011 for more information.

Sincerely,

Gerald D. Dodd, M.D.
President

STATEMENT

Submitted by the

AMERICAN COLLEGE OF PREVENTIVE MEDICINE

The American College of Preventive Medicine (ACPM) is pleased to support H.R. 2565, the Medicare Preventive Benefits Act of 1991. The bill provides crucially important recognition that preventive services should be an integral part of health care for the elderly.

The American College of Preventive Medicine is the national medical specialty society of physicians whose primary interest and expertise is preventive medicine and public health. Our members work in public health agencies, in clinical settings, in industry, and in academia. Most are board-certified in the specialty of preventive medicine. The College membership constitutes a major national resource of expertise in disease prevention and health promotion, areas vital to protecting and improving the nation's health.

Effectiveness of Clinical Preventive Services

The American College of Preventive Medicine has endorsed the recommendations of the U.S. Preventive Services Task Force as minimum standards for preventive care, subject to modification at the discretion of clinicians. These recommendations appear in the Guide to Clinical Preventive Services. The Task Force assessed the effectiveness of 169 preventive interventions using rigorous criteria. Scientific evidence of effectiveness for each intervention was rated according to its quality and reliability, as well as its results. The result of this assessment, which was subjected to review by over 300 outside experts, resulted in recommendations for preventive services organized by age group, and targeted to other specific risk factors.

The Task Force found:

1. Among the most effective interventions available for reducing the incidence and severity of the leading causes of disease and disability are those that address the personal health practices of patients;

2. There is a need for greater selectivity in ordering tests and providing preventive services. The proposed selection of screening tests requires assessment of individual risk factors of the patient; and

3. Conventional clinical activities such as screening may be of less value to patients than counseling and education.

A summary of the Task Force's recommendations for persons age 65 and over is attached to this statement.

Screening for Colorectal Cancer

The U.S. Preventive Services Task Force found insufficient evidence to recommend for or against fecal occult blood testing or sigmoidoscopy as effective screening tests for colorectal cancer in asymptomatic persons. The Task Force also found inadequate grounds for discontinuing these forms of screening where they are currently practiced or for withholding them from persons who request them. However, screening is recommended when certain risk factors are present. These risk factors are: first-degree relatives with colorectal cancer; personal history of endometrial, ovarian, or breast cancer; previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

The recommendations of the Task Force concerning colorectal cancer screening are in contrast to those of the American College of Physicians and the National Cancer Institute, with which the provisions of H.S. 2565 are consistent. There is general agreement that little direct evidence of the effectiveness of colorectal cancer screening exists, and none at present that it reduces mortality from colorectal cancer. The ACP recommendation points to indirect evidence based on the natural history of the disease and the effectiveness of screening tests in concluding that screening should reduce colorectal cancer incidence and mortality.

This difference among respected authorities underscores that, when definitive scientific evidence from randomized clinical trials is unavailable, other knowledge and values must be used in evaluating screening strategies. ACPM believes firmly that rigorous scientific criteria should be used for this purpose, but recognizes that development of guidelines for clinical preventive services is a dynamic process, and current standards should always be subjected to ongoing refinement. Because results of clinical trials for colorectal cancer screening will continue to become available, one approach to this issue would be to authorize the Secretary to limit or revise the indications for this screening in light of new evidence.

OTA Study of Process for Review of Medicare Coverage of Preventive Services

The dilemma concerning the state of knowledge about screening for colorectal cancer is but one example of the complex issues that arise when science, economics, and social values are all factors in determining whether public funds should support particular preventive interventions. ACPM wholeheartedly endorses the provision of H.R. 2565 directing the Office of Technology Assessment to develop a process for consideration of coverage of preventive services under Medicare. Such a process has the potential to enable development of a reimbursement policy for prevention in a systematic and comprehensive fashion.

Medicare Demonstration Projects

ACPM emphatically supports continuation and expansion of the existing demonstration projects for preventive services under Medicare. We suggest, however, that services to be

added to projects be chosen carefully on the basis of the burden of suffering for the target condition and the potential effectiveness of the prevention intervention. To accomplish this, the bill might instruct the Secretary to develop on this basis a list of interventions to be covered in demonstration projects. The Public Health Service, wherein lies much expertise in evaluation clinical preventive services, should be consulted in developing such a list in approval of study methodologies, and in progress reviews. The successor to the U.S. Preventive Services Task Force, the Expert Panel on Preventive Services, should also be involved in these consultative functions.

In addition, consideration should be given to expanding the demonstration to include Medicaid populations. This would enable additional trials to be conducted on preventive services for children and adults under age 65.

It will be important that preventive services other than screening tests be considered in expanded Medicare demonstrations. One example of such a service is smoking cessation counseling. The health burdens and costs of smoking are well known. Moreover, there is now good evidence that smoking cessation decreases mortality even among the elderly. The U.S. Preventive Services Task Force found that a number of clinical trials have demonstrated the effectiveness of certain forms of physician counseling in changing the smoking behavior of patients. There is a need to determine how to encourage clinicians to engage in effective counseling practices and how such practices should be reimbursed.

Other Preventive Services

ACPM strongly supports the provisions of H.R. 2565 concerning immunization, screening mammography, and well child care. The effectiveness of these interventions is beyond dispute, and their inclusion of Medicare wholly justified. We would suggest only that, when these services become financially accessible, the Secretary be instructed to inform providers and beneficiaries of their availability and encourage their use.

Conclusion

The Medicare Preventive Benefits Act of 1991 provides sorely needed attention to this issue through Medicare. It recognizes the need for a sound scientific basis for coverage decisions, and for expanding research in the field. The American College of Preventive Medicine is pleased to support the bill, and stands ready to provide any further information the Subcommittee may require in its deliberations.

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Hayward, R. et al., Preventive Care Guidelines: 1991, Annals of Internal Medicine 1991; 114:758-782.

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Table 7.
Ages 65 and Over
Schedule: Every Year*

Leading Causes of Death:
Heart disease
Cerebrovascular disease
Obstructive lung disease
Pneumonia/Influenza
Lung cancer
Colorectal cancer

SCREENING

History
Prior symptoms of transient ischemic attack
Dietary intake
Physical activity
Tobacco/alcohol/drug use
Functional status at home

Physical Exam
Height and weight
Blood pressura
Visual acuity
Hearing and hearing aids
Clinical breast exam[1]
HIGH RISK GROUPS
- Auscultation for carotid bruits (HR1)
- Complete skin exam (HR2)
- Complete oral cavity exam (HR3)
- Palpation of thyroid nodules (HR4)

Laboratory/Diagnostic Procedures
Nonfesting total blood cholesterol
Dipstick urinalysis
Mammogram[2]
Thyroid function tests[3]
HIGH RISK GROUPS
- Fasting plasma glucosa (HR5)
- Tuberculin skin test (PPD) (HR6)
- Electrocardiogram (HR7)
- Papanicolaou smaar[4] (HR8)
- Fecal occult blood/Sigmoidoscopy (HR9)
- Fecal occult blood/Colonoscopy (HR10)

COUNSELING

Diet and Exercise
Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium[1]
Caloric balance
Selection of exercise progrem

Substance Use
Tobacco cessation
Alcohol and other drugs:
- Limiting alcohol consumption
- Driving/other dangerous activities while under the influence
- Treatment for ebuse

Injury Prevention
Prevention of falls
Safety belts
Smoke detector
Smoking near bedding or upholstery
Hot water heater tamperatura
Safety hemets
HIGH RISK GROUPS
- Prevention of childhood injuries (HR12)

Dental Health
Regular dental visits, tooth brushing, flossing

Other Primary Preventive Measures
Glaucoma testing by aya specialist
HIGH RISK GROUPS
- Discussion of estrogen replacement therapy (HR13)
- Discussion of aspirin therapy (HR14)
- Skin protection form ultraviolet light (HR15)

IMMUNIZATIONS

Tetsnus-diphtheria (Td) booster[5]
Influenza vaccine[1]
Pneumococcal vaccine
HIGH RISK GROUPS
- Hepatitis B vaccine (HR16)

This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:
- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel-related illness
- Prescription drug abuse
- Occupational illness and injuries

Remain Alert For:
- Depression symptoms
- Suicide risk factors (HR11)
- Abnormal bereavement
- Changes in cognitive function
- Medications that increase risk of falls
- Signs of physical abuse or neglect
- Malignant skin lesions
- Peripheral arterial disease
- Tooth decay, gingivitis, loose teeth

*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1 Annually 2 Every 1-2 years for women until age 75, unless pathology detected 3 For women 4 Every 1-3 years 5 Every 10 years

Table 7. Ages 65 and Over — High-Risk Categories

HR1 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease

HR2 Persons with a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi), or those with increased occupational or recreational exposure to sunlight.

HR3 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR4 Persons with a history of upper-body irradiation.

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands), migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR7 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high-risk males planning to begin a vigorous exercise program.

HR8 Women who have not had previous documented screening in which smears have been consistently negative.

HR9 Persons who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR10 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR12 Persons with children in the home or automobile.

HR13 Women at increased risk for osteoporosis (e.g., Caucasian, low bone mineral content, bilateral oopherectomy before menopause or early menopause, slender build) and who are without known contraindications (e.g., history of undiagnosed vaginal bleeding, active liver disease, thromboembolic disorders, hormone-dependent cancer).

HR14 Men who have risk factors for myocardiel infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early-onset CAD) and who lack a history of gastrointestinal or other bleeding problems, or other risk factors for bleeding or cerebral hemorrhage.

HR15 Persons with increased exposure to sunlight.

HR16 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.

THE DIGESTIVE DISEASE NATIONAL COALITION'S STATEMENT IN SUPPORT OF H.R. 2565, "THE MEDICARE PREVENTIVE BENEFITS ACT OF 1991"

The Digestive Disease National Coalition (DDNC) supports federal health care legislation that would provide Medicare coverage of periodic screening of beneficiaries for colorectal cancer.

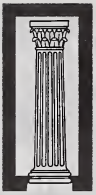
The Digestive Disease National Coalition is an organization comprised of twenty-two voluntary and professional associations representing approximately 500,000 individuals. The DDNC is committed to improved and increased research and treatment of the numerous diseases which afflict the digestive tract, including cancer of the colon and rectum. The member organizations of the Coalition also provide support services and educational materials to individuals who suffer from digestive diseases.

Colorectal cancer is the second leading cancer occurring in the United States. Each year approximately 145,000 new cases are diagnosed. Unfortunately, the overall mortality rate from advanced colorectal cancer remains high, approaching 60%. Early detection and management of this disease however, results in a significant reduction in the mortality rate. In cases where the disease has not reached an advanced stage, the mortality rate is 20%. Currently, diagnostic and therapeutic techniques are available which make early detection and management of this disease possible.

The DDNC supports H.R. 2565 which would expand Medicare benefits to provide coverage for certain preventive measures, including colorectal cancer screening. This legislation would increase access to colorectal screening tests by making the screening tests more affordable. Passage of this legislation would serve as an important first step to ensuring early diagnosis and treatment of this disease. Providing coverage for Medicare beneficiaries is particularly critical since the risk of developing colorectal cancer increases with age.

Colorectal cancer screening will ultimately be cost effective as well, since early detection and treatment will permit patients to return to health and productivity at an earlier time. In addition, early treatment may help to avoid the need for an ostomy (a surgical procedure leaving a patient with an appliance to collect body wastes) and the associated costs of purchasing ostomy supplies. Currently, colorectal cancer accounts for over one half of the 80,000 ostomies performed each year.

The DDNC encourages the use of appropriate screening and periodic examination of persons who do not display symptoms of colorectal cancer, as part of their overall health program. Legislation such as H.R. 2565 will increase access to important early detection methods and may result in reducing much of the personal and financial burdens associated with colorectal cancer.



STATEMENT OF MARTHA McSTEEN, PRESIDENT
NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. On behalf of our 5 million members and supporters, I want to commend you for holding this hearing to bring attention to the issue of preventive care under Medicare.

The National Committee supports the benefits which would become available under the Medicare Preventive Benefits Act of 1991, H.R. 2565--screenings for colon cancer, annual mammograms of older women instead of the current biennial screenings, and well-child care. We are pleased the bill also would cover flu shots for all Medicare beneficiaries--an idea currently being tested in a ten-state and ten-site demonstration program.

We believe these benefits logically and reasonably build on preventive benefits such as pap smears and mammograms added to the Medicare program during the last two legislative sessions. H.R. 2565 assures annual mammograms for all Medicare eligible women--a logical proposal given the fact the rate of breast cancer increases with age. Older women deserve the right to annual breast cancer screenings under Medicare.

A new awareness of the benefits of preventive care clearly has surfaced since Medicare's inception when such services were expressly prohibited from coverage. Our society has gone through major changes in attitudes towards health. We have come to realize that physical exercise, eating habits and regular physician visits, are important factors in staying healthier longer. This awareness has led the private insurance industry to cover more and more preventive screening services. While the oldest of our current senior population may have been affected less by this physical fitness movement and emphasis on preventive care, there is a much greater chance that seniors will use such benefits if they are covered under Medicare.

Breast cancer is one of the leading causes of death in women, second only to lung cancer. According to the National Cancer Institute, the mortality rate is increasing, especially for older women. While conclusive data on the cost savings involved in providing preventive care services is not available yet, it is well-known that early diagnosis and removal of breast cancer malignancies, allows many women to live long, productive lives without reoccurrence of cancer.

H.R. 2565 does not spell out how to finance the proposed benefits. We believe it is essential to seek our members' opinions about a financing plan for this Medicare expansion. It is important to determine, in advance, whether Medicare beneficiaries are able and willing to pay additional monthly premiums in exchange for additional benefits. That is why we plan to poll our members on these and other questions to get a current reading on their experiences and needs.

There is little question that the adherence to a preventive care program will lead to improved productivity, greater longevity and higher quality of life for this nation's seniors, and we applaud you for your persistent efforts to improve and expand the Medicare program.

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